UIC INTERNATIONAL VISITING STUDENT APPLICATION FOR 4-WEEK CLINICAL ROTATION

PART I. TO BE COMPLETED BY THE VISITING STUDENT

NAME (print legibly): _____
Last (Family) Name **First**

Passport–Size Photo

PASTE HERE

Social Security # ___ ___ ___ / ___ ___ / ___ ___ ___ ___ (if applicable)

Permanent Address: _____
House Number **Street** **Apartment/Suite #**

_____
City **State/Province** **Zip/Postal Code** **Country**

Telephone #: _____ Fax #: _____

Pager #: _____ E-Mail: _____

DATE OF THREE PREFERRED ROTATIONS

1. Begin Date: _____/ _____/ _____
2. Begin Date: _____/ _____/ _____
3. Begin Date: _____/ _____/ _____

NAME OF THREE PREFERRED ELECTIVES (AS PUBLISHED IN CATALOG):

1. _____
2. _____
3. _____

Name of Medical School: _____

1. The student will be registered in his/her (4th 5th 6th) year during the proposed elective. ☐ 4th ☐ 5th ☐ 6th

2. The student will attach evidence of student's liability insurance coverage? ◇ Yes ◇ No

3. The student will attach evidence of student's personal health coverage? ◇ Yes ◇ No

4. Will the student have completed the required clerkships (see checklist) ***prior*** to this elective? ◇Yes ◇No

5. The student is aware that a signed letter of academic standing must accompany form to validate application. ◇Yes ◇No

6. Return evaluation to Faculty Member? ◇Yes ◇No

If Yes: _____ _____
Faculty Name & Title **Email Address**

7. The student verifies that all of the above information is correct, to the best of their knowledge, by entering his or her name below.

_____ _____
Full Legal Name **Date**

PART II. TO BE COMPLETED BY UIC COM OFFICE OF INTERNATIONAL EDUCATION

Student meets the requirements of: (a) approval from VS medical school; (b) good standing; (c) completed core clerkships; (d) malpractice coverage; (e) personal health insurance; (f) immunization certification; and (g) citizenship / residency status.

☐ **APPROVED for the elective on this application, ONLY**
☐ **DENIED**

Ara Tekian, PhD, MHPE
Associate Dean for International Education
UIC College of Medicine

_____ _____
Signature **Date Signed**

PART III. TO BE COMPLETED BY THE PROGRAM COORDINATOR OR DESIGNEE AT UIC OR AFFILIATE HOSPITAL

☐ **APPROVED for the elective on this application, ONLY**
☐ **DENIED**

Sonya Forster Raich, Ph.D.

_____ _____ _____
(Print) Name of Program Coordinator or Designee **Signature** **Date Signed**

INTER-OFFICE USE

Evaluation to dept: ___/___/___ Returned to OSA: ___/___/___ Copy to student: ___/___/___ Copy to student's school: ___/___/___ Initials: _____

Rev 9/6/16 SFR