UIC

INTERNATIONAL VISITING STUDENT APPLICATION
4-WEEK CLINICAL ROTATION

NAME: _____
Last (Family) Name **First (Given)**

Passport–Size Photo

PASTE HERE

Permanent Address: _____

_____

Telephone #: _____ Email: _____

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

Month Day Year

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

Name of Medical School: _____

1. Will the student be registered in their final academic year during the proposed elective? ☐ Yes ☐ No
2. Will the student submit evidence of student's liability insurance coverage upon acceptance? ☐ Yes ☐ No
3. Will the student submit evidence of student's personal health coverage upon acceptance? ☐ Yes ☐ No
4. Will the student have completed the required clerkships (see checklist) ***prior*** to this elective? ☐ Yes ☐ No
5. A signed letter of academic standing must accompany form to validate application. ☐ Yes ☐ No
6. Does the evaluation need to be submitted to your home institution? ☐ 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.

_____ _____
Signature **Date**

8. Home Institution Stamp or Seal: ⇨