VCU
Virginia Commonwealth University

APPLICATION FOR ELECTIVE PROGRAMS BY NON-REGISTERED, FULL-TIME VISITING MEDICAL STUDENTS

ATTACH $100 NON-REFUNDABLE APPLICATION FEE. **Foreign Students use a USA Bank check or Cash. Make check payable to VCU SCHOOL OF MEDICINE.**

NAME _____ DATE OF BIRTH _____ SEX _____

ADDRESS _____

PHONE _____ SSN _____

EMAIL _____

COLLEGE TRAINING AND DEGREES PRIOR TO MEDICAL TRAINING

_____

_____

MEDICAL SCHOOL NOW ATTENDING _____

YEARS OF MEDICAL SCHOOL STUDY _____

EXPECTED DATE OF GRADUATION _____

TIME (DATES) YOU WOULD LIKE TO SPEND AT MEDICAL COLLEGE OF VIRGINIA CAMPUS OF VIRGINIA COMMONWEALTH UNIVERSITY _____

ELECTIVE CHOICES

FIRST CHOICE _____ COURSE NO. _____

ALTERNATE CHOICE _____ COURSE NO. _____

ALTERNATE CHOICE _____ COURSE NO. _____

ALTERNATE CHOICE _____ COURSE NO. _____

As a Visiting Student undertaking study at the School of Medicine of Virginia Commonwealth

University, I pledge to abide by the rules and regulations of the Institution. I further am aware of the fact that I must introduce myself to every patient indicating my student status. Also, each party agrees that the Electives Office will retain the right to require the removal from, or deny access to, the Hospital of any Student whose conduct, in the sole opinion of the Elective Preceptor, Elective Coordinator or designee, is:

1. disruptive or otherwise unprofessional;
2. dangerous to the life, health or safety of the Hospital's patients;
3. influenced by the ingestion of alcohol or other intoxicating drugs or substances; and
4. determined to be in violation of any State of Virginia or federal law regulation.

SIGNATURE	**PRINT NAME**	**DATE**

"For and inconsideration of my being allowed to participate in the elective programs for non-registered, full-time medical students offered by the Virginia Commonwealth University, School of Medicine, I hereby release and agree to indemnify and hold harmless the Commonwealth of Virginia, Virginia Commonwealth University and all Officers, Agents, and Employees thereof from any liability, claims or causes of action for personal injury or property damage which may be sustained by me and which may arise from or in any way may be connected with my participation in the aforementioned elective programs offered by the Virginia Commonwealth University, School of Medicine."

SIGNATURE	**PRINT NAME**	**DATE**

YOU ARE RESPONSIBLE FOR FINANCING YOUR TRAVEL AND YOUR OWN LIVING ARRANGEMENTS. PARKING ON MCV CAMPUS - PLEASE CHECK WITH OUR PARKING OFFICE FOR AVAILABILITY WHEN YOU ARRIVE OR YOU MAY CALL AHEAD AT (804) #828-0501. PLEASE LET THEM KNOW THAT YOU ARE A VISITING MEDICAL STUDENT.

Have you already made an approach to an individual unit?
YES - NO (Circle) If yes, which one _____.

Have you applied to any other Medical School for similar training?
_____

After completing this form, this application should be forwarded to the Dean or appropriate Senior faculty member of your Medical School with the request that he/she add their personal comments on the reverse side of this form specifically stating that you are covered by malpractice insurance and have your own personal health insurance coverage. Have them forward these forms directly to:

Dr. Isaac Wood
Associate Dean of Student
Activities & Electives
Virginia Commonwealth University
School of Medicine
MCV Campus Box 980565
Richmond, VA 23298-0565

Please attach a recent photograph. Approximately 3 x 3 inches. Write your name on the back of the photograph.

THIS SECTION TO BE FILLED BY FOREIGN STUDENTS ONLY

YOU MUST HAVE COMPLETED A MINIMUM OF 4 YEARS OF A 6 YEAR PROGRAM BY THE TIME YOU ARE ACCEPTED AT THE VIRGINIA COMMONWEALTH UNIV.

YOU MUST HAVE PROOF OF STUDENT MALPRACTICE LIABILITY INSURANCE AND YOUR OWN PERSONAL HEALTH INSURANCE COVERAGE.

Have you lived or traveled in America previously? ☐ Yes ☐ No

Do you speak English? ☐ Yes ☐ No

Visa status or plans _____

ECFMG Number _____ or date to be taken _____

Country _____

Permanent Resident of _____
COUNTRY