

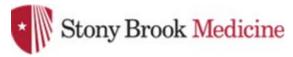
School of Medicine

Visiting Student

Elective Application

Visiting student completes Part I. Part II is completed by Visiting Student's home school Dean. Part III is completed by Stony Brook. All application materials should be submitted to Office of Undergraduate Medical Education, Stony Brook University School of Medicine, Stony Brook, NY 11794-8432 along with a \$25 non-refundable application fee, payable to "SUNY at Stony Brook IFR Account 910759." If approved, a copy of the completed application will be sent back to the student to confirm that an elective is being offered. Part 3 is the elective approval and includes information about attendance on the first day. Availability of a spot in a department does not constitute approval/confirmation that an elective is offered to the student.

PART I – To be completed by student ¹		
NAME		
SSN:	В	irthdate//
Mailing Address: Street	City, Sta	te, Zip
PHONE	email	
Elective Requested		
Course Director	Month/Dates Choice 1	Choice 2
Citizenship: U.S. CitizenNative: Naturalized Place of birtl If non U.S. citizen, country of or Permanent Resident Number Place	n and country citizenship	
Circle third year clerkships which wi	ll be completed at time of	elective:
Medicine Psychiatry Surgery Ob/Gyn	Primary Care Pediatrics Ne	urology Radiology
Attach verification of physical healt and signed by the physician. This he health and does not pose a health rish of immunizations form signed by tetanus/diphtheria vaccine within 10 PPD results within one year of the stactive tuberculosis), and positive V covers the student while at Stony I photocopy of the student's health instantian	ealth assessment must cer to patients or employees a physician, (including) years, Hepatitis vaccine, art date of the requested of aricella titre. Proof of st Brook should also be sub	tify that the student is in good at the Hospital. Attach a record proof of immunity to MMR, Meningitis vaccine or waiver elective (student must be free of tudent health insurance which omitted with the application(a
I,	niversity Hospital employo be released to any person with all Hospital Policies brookhospital.com/index.d licies and Procedures wh	without prior approval from the sand Procedures that can be completed in the control of the cont
STUDENT SIGNATURE		



School of Medicine Visiting Student

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PART II - To be completed by Dean's Office of applicant's school. (Please circle the correct word and fill in the blanks.)

be a full-time year me his/her school during the ele An evaluation <u>is/is not</u> requir not a United States Citizen, the student to attend this cli check are:	named above has permission to take this elective. At the time of the elective, the student will dical student in good standing in a year medical program. The student will pay tuition at ctive period. The student <u>is/is not</u> covered by personal health insurance and is in good health. ed. (If required, please attach form). The student is a United States Citizen or, if the student is the home school can verify that all Passport/Visa information is current and appropriate for nical rotation. The home institution has completed a background check. The results of this If a background check is not conducted, the student will be asked one starting rotation. The above student <u>has/has not</u> completed HIPAA training.
or property of whatsoever k actions of the home instituti shall have liability insurance injury and/or property dama agrees to provide to SUNY S York and the State of New home institution agrees that cancellation, modification of materially relies upon the r	tudent named above shall be responsible for any claims, costs, damages or injuries to personate ind or nature arising out of the activities carried out under this agreement if caused by the on, its officers, students, and/or employees. The home institution represents that the student in amounts not less than \$1,000,000/\$3,000,000 (one million/three million) for any bodily ge arising from the student's activities while enrolled in the elective. The home institution stony Brook on request any insurance certificate(s) and to include the State University of New York as additional named insured under such liability policy or policies if requested. The SUNY Stony Brook will receive no less than thirty (30) days written notice prior to the non-renewal of any insurance coverage. The State University of New York at Stony Brook expresentations by the home institution. SUNY Stony Brook shall remain liable for direct engligence to the fullest extent authorized by law and decisions there-under.
SIGNATURE	TITLE
	DATE
	CHOOL
EMAIL ADDRESS	
School Seal	
Medical Education, zip=	eted by course director at Stony Brook and returned to Office of Undergraduate 8432. Fax 4-9521. NO DATES OF ROTATION
Signature:	Department
UNDERGRADUATE M AT 8:30AM TO PICK U NOT ROTATE WITHO	OF ROTATIONS, THE STUDENT REPORTS TO THE OFFICE OF EDICAL EDUCATION, HSC LEVEL 4, ROOM 157, DEAN'S SUITE, SOM, IP A VERIFICATION OF COMPLETED APPLICATION. STUDENTS MAY OUT THIS SLIP. THIS SLIP WILL BE PRESENTED BY THE STUDENT TO FOR AT THE FOLLOWING TIME AND PLACE:
STUDENT SHOULD RE	PORT TO: Course Director
Dept	Location:
Date:	Time:

Comments:

Reminder to UH Course Director: Please send a copy of the student's completed evaluation form to the Office of Undergraduate Medical Education, Campus Zip=8432, when the student completes this rotation.