



Yale School of Medicine
Visiting Student Elective Program

Student Information

Name: _____ Female/Male: _____
Last First Middle

Social Security Number and/or Passport Number: _____ Birth date: ____/____/____
(mm dd yyyy)

Personal Mailing Address: _____
Street Address City State Country zip/postal code

Email: _____

Telephone: (____) _____ Cell Phone: (____) _____

Nationality: _____

Do you require housing during your elective rotation(s)? _____ Yes _____ No

Medical School Information

Name of school: _____

Mailing Address: _____
Street Address City State Country zip/postal code

Name of Dean: _____ Email: _____

Dean's Office telephone: (____) _____ Fax: (____) _____

Elective

Choices: (1) _____ (2) _____
List a maximum of two choices in order of preference.

Dates desired: (1) _____ (2) _____

I am applying for: <input type="checkbox"/> One elective <input type="checkbox"/> Two electives

I will purchase health insurance and will provide proof of purchase before beginning the elective.

Student signature: _____ Month _____ Day _____ Year _____

To be completed by Applicant's Medical School

This is to certify that the person named above is a student in good standing, has excellent English language skills sufficient to complete a clinical elective, and will be in his/her final year of medical school at the time of the elective period listed above.

Yale University will provide malpractice insurance for visiting International students registered in The Visiting Student Elective Program. Students must provide their own personal health insurance.

Official signature: _____ Month _____ Day _____ Year _____