

STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER

Office of the Registrar
Basic Science Building 1-112, Box 98
450 Clarkson Avenue, Brooklyn, NY 11203
(718)270-4552 (phone) (718)270-7592 (fax)
Email: visitstudent@downstate.edu

International Visiting Medical Student Application

Note: This form, the checklist, the Health Statement Form for Visiting Medical Students and the Letter of Eligibility or Long Term Clerkship Certificate must be printed, filled out and mailed with the appropriate non-refundable certified bank check(s)/money order(s) for \$175 to the address below. Completed applications must be received at least twelve weeks prior to the start of the elective. Late applications will not be processed.

PART A: (To be completed by the student applying for the elective)

Name: _____ Birth Date: _____
Last First (mm/dd/yyyy)

Address: _____
Street City Country

Phone: _____ E-mail: _____ ID/SSN#: _____
(include country code)

Your country of Citizenship: _____

Medical School Presently Enrolled: _____
go to <http://www.who.int/hrh/wdms/en/> (World Directory of Medical Schools) and list the official name of your school as it appears in the directory). If you have attended more than one medical school, list all of the medical schools you have attended.

Dates of Medical School Attendance (list the start date and your expected date of graduation) : _____
If your education has not been continuous for other than vacation periods, indicate the time periods that you were on a leave of absence and the reason(s). Attach an additional sheet if necessary. _____

School Address (street, city, province/state, country & postal code): _____

Medical School Phone Number (county code, city code, phone): _____ Fax Number _____

List the Name of the Hospital, affiliated with your medical school, where students complete their clinical education
(name, city, state, country) _____

Print the Name of your Medical School Advisor (first name, family name) _____

Have you been convicted of any crime? Circle No/Yes. If yes, please attach a sheet and explain in detail.

List family members (father/mother/brother/sister) who are ALUMNI or FACULTY of SUNY Downstate Medical Center

Language Skills: a) Language Spoken in your home _____
b) Language of Instruction in your medical school classes _____
c) Language you speak most frequently in the clinical setting _____

English Language Skills: (Circle the correct choice) If you have taken the TOEFL or TSE exams, send a copy of your exam report
Spoken Fluent Good Fair Poor
Written Excellent Good Fair Poor

If English is **not** your native language, **briefly explain where and for how many years you have studied English.**

I certify that the information submitted in this application and associated materials are complete, accurate, and correct to the best of my knowledge. I also understand that misrepresentation will lead to a denial of my application and/or immediate removal from the elective.

Applicant Signature

Date (mm/dd/yyyy)

Print Your Name: _____

ELECTIVE(S) REQUESTED

TITLE: _____

COURSE#: _____

DATES REQUESTED: 1st CHOICE _____

2nd CHOICE _____

Note: After the third postponement or cancellation of an approved elective, there will be an 18 month waiting period before we will accept another application from you.

PART B: (To be completed by the Dean or designated official of the medical school where the student is presently enrolled)

- Is this student in good academic standing? YES NO
- Is this student approved to take this elective for credit? YES NO
- Does malpractice insurance cover this student during rotation away from his/her school? (proof required) YES NO
- Is the student's personal health insurance coverage in effect while away from his/her school? (proof required) YES NO
- At the end of the clerkship an evaluation form will be required (please see attached form) YES NO
- An official transcript in a sealed envelope must accompany this application (attached) YES NO
- Passport size photo (attached) YES NO
- Has this student passed Step 1 of either USMLE or COMPLEX? If yes, please circle which exam. Attach score report YES NO
- Was "Letter of Eligibility" mailed with fee (\$30) to New York State? YES NO Date: _____
(mm/dd/yyyy)

Check the Core Clerkships the student will have completed by the time of the elective and indicate any Grades received.

- Medicine & Grade _____ OB/GYN & Grade _____ Psychiatry & Grade _____ Surgery & Grade _____ Pediatrics & Grade _____
- Neurology & Grade _____ OTHER: _____

Expected Date of Completion of Degree _____
(mm/dd/yyyy)

Rank in Class _____ of a class size of _____

How many weeks of Clerkships may a student take away from your location? _____ weeks of _____ total weeks of clerkships

How many weeks of Electives may a student take away from your location to meet graduation requirements for the MD degree? _____ weeks of _____ total weeks of electives required for graduation.

Name/Title of Official: _____ SCHOOL SEAL:

Signature: _____ Date: _____
(mm/dd/yyyy)

PART C: (To be completed by Downstate Medical Center Department Chairperson or Elective Coordinator)

This visiting student's elective request: _____ Approved _____ Not Approved

Signature: _____ Date: _____

Student should report on first day of rotation to: _____

Preceptor: _____

Telephone Contact: _____ Date: _____ Time: _____
(mm/dd/yyyy)

Please return completed form to: SUNY Downstate Medical Center 450 Clarkson Avenue, Box# 98 Brooklyn, New York 11203
Attn: Sandra Mingo