Albert Einstein College of Medicine
Visiting Exchange Student Elective Application

PART I **(To be complete by Applicant)**

_____ _____

Last **First** **Middle** **DOB** (MM/DD/YEAR)

_____

Mailing Address

Male / Female

_____

City **State** **Zip**

Are you a U.S. citizen? Yes □ No □
If No:
Country of Citizenship _____

Are you requesting Housing accommodations on the Einstein Campus?
Yes □ **No □**

Country of Birth _____

_____ _____

Email Address **Phone Number**

_____

Home Medical School

- □ I have participated in educational activities applicable to eliciting a general medical history, screening general physical examination, and obtaining vital signs appropriate to the training level of an advanced medical student (MS-III, MS-IV).
- □ To the best of my knowledge, I do not currently have a clinical condition that poses an acute danger to patients or co-workers through my participation in clinical rotations. I have no physical or mental health conditions which would now adversely affect or which may reasonably progress to a point of affecting my ability to perform professional, clinical, or other student trainee duties.

I understand that the Albert Einstein College of Medicine provides no medical coverage and assumes no liability for any medical cost incurred by me while I am participating in an elective at that school. I agree to notify the Office of the Registrar prior to my scheduled elective course date should I not be able to take the elective. I understand that notification of acceptance into any elective cannot be given until Einstein senior elective registration is complete.

I attest that the information provided above and any associated information, which I have provided in reference to this request for clinical duty privileges, is true and complete. I understand that providing false, misleading, or intentionally incomplete information may provoke immediate suspension from duties, at a minimum.

_____ _____

Applicant's Signature **Date**

First Choice:

_____ _____ _____ / _____

Course No. Elective Title Start Date End Date

Alternate Dates: _____ / _____
Start Date End Date

Second Choice:

_____ _____ _____ / _____

Course No. Elective Title Start Date End Date

Alternate Dates: _____ / _____
Start Date End Date

PART II **(To be completed by the Dean of Students or other authorized medical school official)**

Please specify the date that the student completed the following clinical clerkships:

Medicine	Surgery	Ob/Gyn	Radiology
Pediatrics	Psychiatry	Geriatrics	Family Medicine

☐ Current Basic Life Support (BLS) certification _____
Expiration date

At the time of the elective the student named above will be a _____ year student in a _____ year program. He/She is in good standing at this institution and has my approval to participate in the elective specified above. The student will pay tuition at this institution during the period above. Health insurance is in effect away from the school. Professional liability does cover the student away from this school. At the conclusion of this elective an evaluation will be required.

_____ _____
Name (print or type) Title

_____ _____
Signature Date

Official
School Seal

For Each elective Applicants must submit the in the **EXACT ORDER LISTED**:

1. Visiting Student Elective Application
2. Approval Letter from authorized Home Medical School official
3. Completed Health/Immunization form
4. Curriculum Vitae
5. Official Transcript
6. Photo-passport size (stapled to application)
7. Copy of Personal Health Insurance Card (front and back)
8. Copy of current BLS/ACLS card.
9. Copy of HIPPA Certificate
10. Copy of Mask-fit testing
11. Copy of OSHA/Infection Control

Passport size
Photo

Email Application and supporting documents as a PDF file to:

Einstein-MDRegistrar@einsteinmed.org