

## ELECTIVE PROGRAM APPLICATION

### INSTRUCTIONS

Part A of this application must be completed by the student, Part B by the Dean or a senior official of the medical school administrative staff. Students must submit an official transcript.

Please note that this application will **NOT** be processed unless all materials are provided. This form must be submitted at least three months before the desired starting date. We can make no arrangements until this form is completed and returned. The complete senior elective guide is on the World Wide Web at:

<http://www.med.wayne.edu> students' section

No student may apply for more than twelve weeks of elective time. Electives begin on the 1st day of the month and end on the last day of the month. You must be in the final year of medical curriculum. You must have taken and passed the National Board of Medical Examiners, Step I of the United State Medical Licensing Examination (USMLE). You must be in the final year of medical curriculum. The elective period must be a required part of your curriculum and you must have completed a minimum of one year of clinical rotations before the elective begins.

The School of Medicine requires that all students working in hospitals must have immunizations for measles (Rubeola & Rubella), documentation of current TB status and Hepatitis B. We include the details on the attached form **THAT MUST BE COMPLETED AND SIGNED BY A PHYSICIAN BEFORE THIS ELECTIVE APPLICATION WILL BE PROCESSED.**

It is the responsibility of each visiting foreign student to obtain a visa, as required by US Department of Immigration & Naturalization Service.

Students are personally responsible for any health costs incurred during the elective time spent at Wayne State University School of Medicine.

Although we will try to grant your request, please be advised that it is not always possible to do so. Please return the elective application to:

Mrs. JaEsta Jones, Supervisor  
Records & Registration Office  
Wayne State University School of Medicine  
540 East Canfield  
Detroit, MI 48201

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE  
Visiting Student Application for Elective Clerkships

**PART A**

Name \_\_\_\_\_ Social Sec. # \_\_\_\_ -- \_\_\_\_ -- \_\_\_\_  
 (last, first middle)

Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Telephone: \_\_\_\_\_

Name of your medical school \_\_\_\_\_

Date you expect to complete your degree \_\_\_\_\_

Choice of Electives:

Specialty or area of interest desired, location	Dates Desired:			
1st _____	_____	or	_____	_____
2nd _____	_____	or	_____	_____
3rd _____	_____	or	_____	_____

\_\_\_\_\_

Student Signature Date

Certification of your status and recommendation from your dean (Part B on reverse) must be completed.  
 \*\*\*\*\*

For each discipline listed below, please indicate any clerkship experiences in which you have had full-time responsibility for patient care in the hospital setting. Please also list any additional clerkships you expect to complete before the time you plan to arrive at Wayne State University School of Medicine. Official Transcript required.

<u>Clerkship</u>	<u># Weeks</u>	<u>Location</u>	<u>Dates</u>
Medicine	_____	_____	_____
Surgery	_____	_____	_____
Pediatrics	_____	_____	_____
OB/GYN	_____	_____	_____
Psychiatry	_____	_____	_____
Other:			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE  
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**PART B: To be completed by Dean of Medical School:**

I confirm that \_\_\_\_\_ is a full-time medical student in good standing at this school and has permission to take an elective at the Wayne State University School of Medicine. I hereby certify that this student will be in the final year of our program and will have, at the time of the elective is undertaken, sufficient clinical experience to competently examine patients. If furthermore confirm that the student can read, write and speak English well enough to examine a patient and record the results in the patient's record.

This student has taken and passed USMLE, Step I yes    no  
Date taken \_\_\_\_\_ Total Score \_\_\_\_\_

This student will pay tuition at our school during the period indicated yes    no

Personal health coverage is in effect while this student is away from our school yes    no

Malpractice/professional liability insurance covers the student away from our school yes    no

Academic credit toward the M.D. degree will be awarded upon receipt of a passing grade yes    no

An evaluation of the student's performance will be required yes    no

Medical School \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Title

*School Seal*

Please return this form to: Mrs. JaEsta Jones, Records & Registration Office, Wayne State University School of Medicine, 540 East Canfield, Detroit, MI 48201

