

**UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE
VISITING STUDENT APPLICATION**

Complete form and return to the Student Affairs Office, University of Louisville School of Medicine, 404 Abell Administration Building, 323 E. Chestnut Street, Louisville, KY 40202-3866. (502) 852-5192 or Fax (502) 852-0302

SECTION I: (To be completed by student)

Name, Address, & Phone Number

Medical School Name & Address

E-Mail Address: _____

Social Security Number: _____

Date of Birth: _____

Country of Citizenship: _____

Sex: Male Female (Circle One)

Native First Language: _____

Ethnic Code: 1 - Non Resident Alien, 2 - Black, Non-Hispanic, 3 - American Indian/Alaskan Native, 4 - Asian or Pacific Islander, 5- Hispanic, 6 - White, Non-Hispanic

I hereby verify that the above information is correct and that I have health insurance that covers me at all times.

Signature

Date

Clinical Course Desired: (Please list first choice and two alternate choices)

1.	_____	_____	_____	_____
	Department	Course Number	Course Name	Dates Requested
2.	_____	_____	_____	_____
	Department	Course Number	Course Name	Dates Requested
3.	_____	_____	_____	_____
	Department	Course Number	Course Name	Dates Requested

SECTION II: (To be completed by school official at student's medical school.)

School Seal

NOTE: Requests must be received at least four months prior to beginning requested rotations.
(Please Circle)

Will this course count towards the student's graduation requirements?	Yes	No	
Will an evaluation form be required at the end of the program?	Yes	No	
Will tuition be paid at your school during the period away?	Yes	No	
Is the student covered by malpractice insurance?	Yes	No	
Please circle the student's class rank:	Upper	Middle	Lower

Name of Official: (Print) _____ Title: _____

Signature of Official

Date

SECTION III: (To be completed by Dept. at U of L and returned to the Student Affairs Office.)

Your application for the clinical program has been:

Approved: Yes No Course #: _____ for following dates: _____

Department Signature: _____ Date: _____

Phone Number: _____

SECTION IV: (To be completed by Dean's Office at the University of Louisville School of Medicine)

A copy of this form will be sent to the student and the Department after it has been processed in the Dean's Office. The Dean's Office action is the final decision.

Approved: Yes No _____
Dean's Office Signature

Date