

Weill Cornell Medical College

Application for Elective Study CANADIAN STUDENTS ONLY

SECTION I: PERSONAL INFORMATION (To be completed by student)

Last Name	First Name	Current Medical School	
Date of Birth	Social Security No. (for verification purposes only)	Expected Degree	Graduation Date
Student Mailing Address		Registrar's Office Address	
STREET		STREET	
CITY	STATE ZIP	CITY	STATE ZIP
Student E-mail	Student Phone	Registrar's Phone	Registrar's Fax

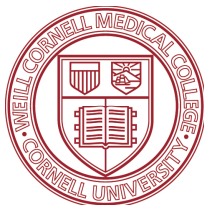
I understand that the application materials submitted become the property of Weill Medical College. I attest that the information given in this application to be true and accurate.

Student's Signature: _____ Date: _____

SECTION II: ELECTIVES REQUESTED (To be completed by student)

Please list in order of priority. It is helpful if you list a few requests in case your top choice of course or date is unavailable.

Inclusive WCMC Elective Dates	Course Number	Title of Elective
1.		
2.		
3.		
4.		
5.		



Weill Cornell Medical College

Application for Elective Study Visiting Students

SECTION III: DEAN OR REGISTRAR VERIFICATION (To be completed by authorized official of student's school)

Student Last Name	Student First Name	Current Medical School (Home Institution)

• This student will enter his/her fourth year on ____/____/____ month date year		
• Student's expected graduation date ____/____/____ Degree: month date year		
• This student is in good academic standing at home institution	Yes	No
• This student will pay tuition at home institution during the period indicated	Yes	No
• Personal Health Insurance Coverage is in effect while the student is away from home institution	Yes	No
• Malpractice insurance is in effect while away from home institution	Yes	No
• This student has completed HIPAA training (required for WMC enrollment)	Yes	No
• This student has completed OSHA training (required for WMC enrollment)	Yes	No
• This student will receive credit for this elective	Yes	No
• At the end of the elective, an evaluation will be required <i>Please do not include any evaluation in this application packet- student must provide instructor with form</i>	Yes	No

***A raised school seal must be affixed to this document.**



School Official's Name: _____

School Official's Title: _____

Signature: _____

Date: _____

Please submit all materials to:
Electives Coordinator
Weill Cornell Medical College
1300 York Avenue, C-118
New York, NY 10065
electives@med.cornell.edu