OREGON HEALTH & SCIENCE UNIVERSITY
APPLICATION FOR VISITING STUDENT ELECTIVE COURSES
(For use by students attending LCME or EDAOA Medical Schools only)

APPLICANT NAME: SOCIAL SECURITY NUMBER*:		**OFFICE USE ONLY:** **ELECTIVE:**
MAILING ADDRESS:		**DATES:** **EMAIL:** (Please Print Clearly)
DAY PHONE:	EVENING PHONE:	

Please attach a photo, current medical school transcript and proof of successful completion of USMLE or NBOME Step 1.

TO BE COMPLETED BY THE APPLICANT'S ASSOCIATE DEAN OR REGISTRAR:

CIRCLE ONE

1. Is the above named applicant is in good standing at this institution and is authorized to take a visiting elective course at Oregon Health & Science University? YES NO
2. Does the applicant have malpractice insurance as a visiting student? YES NO
3. Does this applicant have major medical insurance which will be in effect at OHSU during this elective? YES NO
4. This applicant has completed the following immunizations: RUBEOLA, RUBELLA, MUMPS, DIPHTHERIA-TETANUS, POLIO, TUBERCULIN STATUS, HEPATITIS B and CHICKEN POX. YES NO
5. A student evaluation for this elective will be required. (It is the applicant's responsibility to bring or send the required form to OHSU). YES NO
6. Indicate which third year core rotations the student will complete prior to coming to OHSU.

(Please circle) **INTERNAL MED SURG PEDS PSYCH OB/GYN FAMILY MED**

Permission by the Parent Institution is given to take a clinical elective for graded credit at OHSU. The elective course is consistent with the applicant's education needs.

SCHOOL SEAL:

_____
Print name and title of school official completing this form

_____
Signature of school official completing this form

Name of Medical School: _____

Medical School Address: _____

_____

School Phone Number: ( ) _____

_____
Signature, OHSU Supervising Department Date

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OREGON HEALTH & SCIENCE UNIVERSITY

Dates must correspond to our Clinical Elective Schedule (See website for current schedule):

Please specific the Clinical elective for which application is made. Because many electives will fill with OHSU students, it is suggested that you list 2 or 3 choices in order of preference.)

Department/Course Title	Inclusive Dates of Elective
1st Choice:	to
2nd Choice:	to
3rd Choice:	to

RETURN THIS FORM TO:

Marcia DeCaro
Education and Student Affairs, L102
Oregon Health & Science University
3181 SW Sam Jackson Park Road
Portland, OR 97239-3098
e-mail: decaro@ohsu.edu
(503) 494-4101

***Social Security Number Disclosure and Consent Statement**

You are requested to provide voluntarily your Social Security Number to assist OHSU (and organizations conducting studies for or on behalf of OHSU) in developing, validating, or administering predictive tests; administering student aid programs; improving instruction; internal identification of students; collection of student debts; or comparing student educational experiences with subsequent workforce experience. OHSU will disclose your Social Security Number only if the studies are conducted in a manner that does not permit personal identification of you by individuals other than representatives of OHSU (or the organization conducting the study for OHSU) and only if the information is destroyed when no longer needed for the purpose for which the study was conducted. By providing your Social Security Number, you are consenting to the uses identified above. This request is made pursuant to ORS 351.070 and 351.085. Provision of your Social Security Number and consent to its use is not required and if you choose not to do so you will not be denied any right, benefit, or privilege provided by law. You may revoke your consent for the use of your Social Security Number at any time by writing to: Oregon Health & Science University, School of Medicine, Office of Education and Student Affairs, L102, 3181 SW Sam Jackson Park Road, Portland, Oregon 97239-3098.