

**APPLICATION FOR ADMISSION AS A VISITING MEDICAL STUDENT**  
 (Truman Medical Centers West and East, St. Luke's Hospital, Children's Mercy Hospital, & Western Missouri Mental Health Center)  
**TO BE COMPLETED BY STUDENT APPLYING FOR ELECTIVE**

**Section A:**

Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Sex: \_\_\_\_\_  
Last First MI

Birth Date: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
mo/day/year city state/country

Present Address:  
 No & Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Permanent Address:  
 No & Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Medical School Now Attending: \_\_\_\_\_ Year Level: \_\_\_\_\_

1. Elective Desired: \_\_\_\_\_  
Title Hospital Physician

For the Period Beginning: \_\_\_\_\_ Ending: \_\_\_\_\_

2. Elective Desired: \_\_\_\_\_  
Title Hospital Physician

For the Period Beginning: \_\_\_\_\_ Ending: \_\_\_\_\_

3. Elective Desired: \_\_\_\_\_  
Title Hospital Physician

For the Period Beginning: \_\_\_\_\_ Ending: \_\_\_\_\_

**TO BE COMPLETED BY THE DEAN OF THE MEDICAL SCHOOL WHERE STUDENT IS ENROLLED**  
**SECTION B:**

- Student \_\_\_ is \_\_\_ is not in good standing at this institution.
- School \_\_\_ is \_\_\_ is not accredited by LCME.
- Student \_\_\_ will \_\_\_ will not pay tuition at enrolled school during the period indicated.
- Malpractice insurance \_\_\_ does \_\_\_ does not cover student while away from enrolled school.
- Student is approved to take this elective for \_\_\_ credit \_\_\_ not for credit.
- Personal health coverag \_\_\_ is \_\_\_ is not in effect while away from enrolled school.
- An evaluation \_\_\_ will \_\_\_ will not be required.

Student will have completed the following by the date he/she wishes to begin the clerkship as a visiting medical student:

___ Weeks of Basic Medicine	___ Weeks of Basic Psychiatry	Other: _____
___ Weeks of Basic Surgery	___ Weeks of Basic Ob/Gyn	Other: _____
___ Weeks of Pediatrics	Other: _____	Other: _____

\_\_\_\_\_  
 School Official Signature

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Name (print)

\_\_\_\_\_  
 Date

**IMMUNIZATION REQUIREMENT: STUDENT MUST HAVE SCHOOL'S HEALTH OFFICIAL CERTIFY THE ATTACHED IMMUNIZATION/TEST RECORD FOR VISITING STUDENTS.**