

# **TEMPLE UNIVERSITY SCHOOL OF MEDICINE**

## **INSTRUCTIONS FOR VISITING STUDENT APPLICATION**

### **TO BE ELIGIBLE YOU MUST:**

- 1) Be a student currently in good standing at an LCME or AOA accredited medical school and at the time of the elective, **you must be in your fourth year** of medical school.
- 2) Submit verification of completion of core clerkships of at least six (6) weeks duration in each of the following disciplines: Family Medicine/Primary Care, General Internal Medicine, Obstetrics/Gynecology, Pediatrics, Psychiatry, and General Surgery. No Temple elective rotation will be approved for a discipline in which prerequisite core clinical experience will not have been satisfactorily completed prior to the start of the requested rotation.
- 3) Attach documentation to the effect that you are covered by medical liability/malpractice insurance and personal health insurance; immunizations (using Temple form) **are current and complete**; and bloodborne/airborne pathogens training has been completed during the current academic year.
- 4) Specify desired course and location. Requests for "any hospital" or "any subspecialty" are unacceptable.

### **YOU SHOULD KNOW:**

- 1) Visiting Student applications will not be accepted before March 1<sup>st</sup> for the following academic year and will be considered only after schedules have been completed for all Temple students (approximately May 15th).
- 2) Visiting students may be approved for a maximum of two 4-week rotations.
- 3) All documentation supporting your **application must contain original signatures and school seal**. Photocopies/faxes are unacceptable.
- 4) Temple does not provide housing.
- 5) Parking and meals are available for a fee.

**XX**

Visit our website at: [www.medschool.temple.edu](http://www.medschool.temple.edu) and click onto Prospective Students.

**ONLY ORIGINAL AND FULLY COMPLETED FORMS WILL BE ACCEPTED!**

### **MAIL APPLICATION TO:**

**TEMPLE UNIVERSITY SCHOOL OF MEDICINE  
Office of Academic Affiliations  
Cancer Center Bldg., Suite 203  
3322 North Broad Street  
Philadelphia, PA 19140-5199**

**TEMPLE UNIVERSITY SCHOOL OF MEDICINE  
APPLICATION OF STUDENT FROM LCME/AOA-ACCREDITED MEDICAL SCHOOL  
FOR ELECTIVE**

**SECTION 1: To be completed by APPLICANT**

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

STREET

CITY

STATE

ZIP

Email \_\_\_\_\_ SS# \_\_\_\_\_

Medical School \_\_\_\_\_ Expected Date of Graduation \_\_\_\_\_

I wish to apply for one  two  rotation(s). Courses in order of preference are:

Title (and # if known)

Location

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

In order of preference, I wish to be scheduled for Temple blocks  or

I am available only from \_\_\_\_\_ through \_\_\_\_\_

Signature \_\_\_\_\_

**SECTION 2: To be completed by DEAN'S OFFICE of applicant's school**

Please circle the appropriate responses.

*This is to certify that the above named student has/has not completed all required core clerkships. S/he is/is not in good standing at this institution. S/he does/does not have our permission to take the above listed course for elective credit. Malpractice insurance does/does not cover the student while away from our school. Personal health coverage under school policy does/does not cover the student while away from our school. Bloodborne & airborne pathogens training has/has not been taken during the current year.*

Family Practice \_\_\_\_ wks.

Internal Medicine \_\_\_\_ wks.

Pediatrics \_\_\_\_\_ wks.

OB/GYN \_\_\_\_ wks.

Psychiatry \_\_\_\_ wks.

General Surgery \_\_\_\_ wks.

Date: \_\_\_\_\_ Title \_\_\_\_\_ Signature \_\_\_\_\_

School Seal

**SECTION 3: To be completed by COURSE DIRECTOR OR INSTRUCTOR (TUSM Responsibility)**

The application of the above-named student is/is not approved for \_\_\_\_\_

from \_\_\_\_\_ through \_\_\_\_\_.(S)He should report on \_\_\_\_\_

to \_\_\_\_\_

NAME AND PLACE

Signature \_\_\_\_\_

**SECTION 4: To be completed by ADMINISTRATIVE COORDINATOR FOR CURRICULUM (TUSM)**

Approved  Not Approved  Signature \_\_\_\_\_ Date \_\_\_\_\_

**TEMPLE UNIVERSITY STUDENT HEALTH SERVICES**  
**HEALTH STATEMENT FOR VISITING STUDENTS**

NAME: \_\_\_\_\_

**Last**

**First**

**MI**

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Elective Dates (mo/yr): \_\_\_\_\_ to \_\_\_\_\_

**Note:** If you will be working with animals or their tissues, please consult your department for any further immunization requirements.

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

IMMUNIZATION	DATE(S) GIVEN	TITER (*=REQUIRED)		For TUSM-SHS Use UNSATIS	Only SATIS
		DATE	RESULT		
<b>Rubeola:</b> 1 <sup>ST</sup> dose must be after 1 <sup>st</sup> birthday	_____		*		
<b>Rubella:</b>	_____		*		
<b>Mumps:</b>	_____				
<b>Varicella:</b>	_____		*		
<b>HepatitisB:</b>	_____				
<b>Dip/tet:</b>					
<b>Primary series</b>	_____				
<b>Booster (most recent must be within 10 years)</b>	_____				
<b>Polio:</b>	_____				
<b>PPD:</b> required for all students <i>except</i> where there is a history of <i>PREVIOUS POSITIVE PPD</i>	_____ or _____ Date of last PPD                      Year of positive PPD	_____ mm <b>induration</b>			
<b>CXR:</b>	Required for students with new or past positive (>=10 mm, or >=5mm if immunocompromised) PPD, regardless of BCG history.  DATE of CXR: ____/____/____	CXR Result: _____ _____ _____			

\_\_\_\_\_ / \_\_\_\_\_ MD/DO/NP

Date: \_\_\_\_\_

*Print name*

*Signature of health care provider*

## COURSE CATALOGUE

Information on courses currently offered may be found on the Temple University School of Medicine  
Website at <http://www.medschool.temple.edu/electivecatalog>

## *Housing*

Website of possible interest to students and/or residents looking for temporary housing.

[4wallsinphilly.com](http://4wallsinphilly.com)