



Office of the Registrar
 College of Medicine
 University of South Florida
 Phone: (813) 974-0828

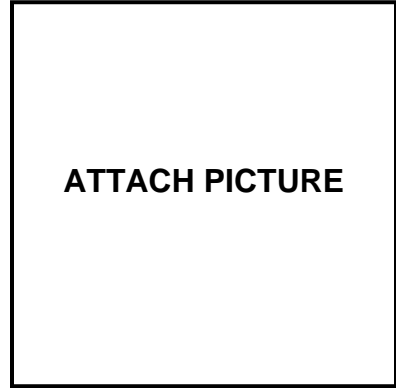
12901 Bruce B. Downs Blvd MDC 32
 Tampa, FL 33612
 Email: mcook@health.usf.edu
 Fax: (813) 974-4619

Visiting Student Application

A separate application must be completed if requesting electives from more than one department (Appendix A Only). All applications and required paperwork **MUST BE RECEIVED** one month **BEFORE** the **START** of the elective.

PART I: TO BE COMPLETED BY THE VISITING STUDENT

Student Name _____
 Home Phone _____ Date of Birth _____ Social Security # _____
 Student Mailing Address _____
 City _____ State _____ Zip _____
 Student E-mail Address _____
 Citizenship Status (Please check one) US Citizen Permanent Resident Foreign National



SCHOOL SEAL MUST BE IMPRINTED OVER PICTURE. FORM WILL NOT BE ACCEPTED WITHOUT ATTACHED PICTURE AND OFFICIAL SCHOOL SEAL.

Anticipated Graduation Date _____
 Currently enrolled at _____ as a _____ year student.
 Primary course title _____ Site _____
 Inclusive date of course _____ to _____
 Alternate course title _____ Site _____
 Alternate dates _____ to _____
 Health coverage is provided by _____
 (Name of Insurance Company AND Policy Number)

I understand that courses are filled on a first come first served basis and that my application will not be considered until ALL application, immunization, and insurance requirements have been satisfied.

Student Signature _____ Date _____

PART II: TO BE COMPLETED BY DEAN OF STUDENT AFFAIRS, REGISTRAR, OR DESIGNATED OFFICIAL AT THE UNIVERSITY OF THE VISITING STUDENT

The medical student named above is a 4th year student in GOOD STANDING at this institution, will have taken and passed ALL core clerkships (Internal Medicine, Surgery, Psychiatry, Pediatrics, OB/GYN, Family Medicine), and has permission to take the above listed course for elective credit. The student will pay tuition at our institution and IS COVERED FOR LIABILITY OR MALPRACTICE INSURANCE DURING THE PERIOD INDICATED for no less than the amount of \$100,000/200,000, and a **certificate of coverage is attached**. A final elective evaluation for this student is is not required. Our student evaluation form is is not included.

Signature _____ (Dean/Registrar/or Designated Official) _____ (Date)

Name and Title of Official (please print) _____

Official's E-mail Address _____

School address and phone # _____

PART III: TO BE COMPLETED BY USF DEPARTMENTAL CHAIR OR DESIGNATED ELECTIVE COORDINATOR

This request is _____ Approved _____ Not Approved

The student will report on (date) _____

Signature _____ (Departmental Chair or Designated Elective Course Coordinator)

Please send this completed application, immunization form, student evaluation form (if required), and insurance information as a single package to the USF College of Medicine Registrar at the address listed on the top of this form.