

*Elective Application for  
Visiting Medical Students*

**PART I (To Be Completed by Student)**

Applicant's Name: \_\_\_\_\_ ID# \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street Address City State Zip Code

Telephone Number: \_\_\_\_\_ Medical School: \_\_\_\_\_

Expected Graduation Date: \_\_\_\_\_

**ELECTIVES DESIRED**

1. \_\_\_\_\_ to \_\_\_\_\_  
Primary request Course #
2. \_\_\_\_\_ to \_\_\_\_\_  
Alternate request Course #
3. \_\_\_\_\_ to \_\_\_\_\_  
Alternate request Course #

I understand that Penn State University College of Medicine (PSUCOM) assumes no liability for professional liability arising from my participation in elective or clinical rotations at PSUCOM or for any medical costs incurred by me while I am participating in an elective at their school. If accepted, I understand I am required to review the University's HIPAA policies and procedures prior to the first day of the elective. I agree to notify the appropriate department prior to my scheduled elective course dates should I not be able to take the elective. I understand that notification of acceptance into my elective cannot be given until after PSUCOM senior elective registration is completed.

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART II (To Be Completed by Dean of Student's School)**

**ACADEMIC STANDING**

- |   | Yes   | No    |
|---|-------|-------|
| 1. This school is an LCME accredited school.  | _____ | _____ |
| 2. The above student is in good academic standing at her/his school and has my approval to participate in the elective(s).  | _____ | _____ |
| 3. The student will be officially matriculated at this medical school in her/his senior year of medical curriculum (U.S. medical School's fourth year or its equivalent, e.g., sixth year of six-year program).   | _____ | _____ |
| 4. The student will have completed this school's entire core curriculum including one full year of clinical training prior to the requested elective dates.   | _____ | _____ |
| 5. The student's personal health coverage will be in effect through the visiting student's school while the student is participating in the elective(s) at PSUCOM. Please include documentation of proof of personal health coverage with your application.   | _____ | _____ |
| 6. The student's professional liability insurance will be in effect through the visiting student's school while the student is participating in the elective(s) at PSUCOM. PSUCOM minimal coverage limits are \$1,000,000 (1 million)/per incident and \$3,000,000 (3 million)/annual aggregate. Please include documentation of proof of insurance and coverage amounts with your application. | _____ | _____ |
| 7. The student has completed a program on universal precautions ensuring the appropriate handling of blood, tissues, and body fluids.   | _____ | _____ |
| 8. The student has completed a program in Health Insurance Portability and Accountability Act (HIPAA) ensuring the appropriate handling of protected health information.  | _____ | _____ |
| 9. The student is receiving academic credit for his/her participation in this elective.   | _____ | _____ |
| 10. A written evaluation of student's performance will be required upon completion of this elective. I understand that if an application form is not provided from the applicant's home school at the start of the elective, PSUCOM will use their student evaluation form.   | _____ | _____ |

Name of Student: \_\_\_\_\_ Expected date of graduation from medical school: \_\_\_\_\_

\_\_\_\_\_  
Name of Dean (or her/his designee)

\_\_\_\_\_  
Title

\_\_\_\_\_  
School

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
School Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

**Place School Seal Here**

\_\_\_\_\_  
Signature of Dean (or his/her designee)

**PART III (To Be Completed by PSUCOM faculty or designee)**

Elective Confirmed: \_\_\_\_\_ Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

(please print)

Approved by (signature): \_\_\_\_\_