



**VISITING STUDENT ELECTIVES PROGRAM
APPLICATION FORM
(Canadian/U.S. Medical Students)**

**Undergraduate Medical Education
Faculty of Medicine
Room 2743 - The Health Sciences Centre
St. John's, NL A1B 3V6 CANADA**

Part A: To Be Completed by Student (Print)

Surname	Given Name	Date of Birth (mm/dd/yy)	Gender	Citizenship

Mailing Address

Street	Apt. #	City	Prov.	Postal Code

Tel. No.	E-mail Address	Fax No.

Next of Kin

		Tel. No.
Name	Mailing Address	E-mail

Name of Medical School _____
 Current Year of study: _____ Length of Program: _____

List in order of preference your elective choices and dates of your chosen block(s)

1 st Choice	2 nd Choice
Discipline:	Discipline:
Sub-specialty:	Sub-specialty:
Date of Block: From - (mm/dd/yy) To -	Date of Block: From - (mm/dd/yy) To -

If you have already contacted a potential supervisor, please provide the following information:

Name _____ Tel. No. _____

Hospital _____

Student's Signature _____ Date _____

Part B: To Be Completed by the Dean or Designate

This is to confirm that the above-named student is in good standing and currently registered in _____ Year at this university.

Assessment of Academic Ability	Above Average	Average	Below Average
Assessment of Clinical Ability	Above Average	Average	Below Average

Will the student be covered by liability insurance by your institution? Yes No
 Will the student be covered by personal health insurance? Yes No

The student is authorized and approved to complete electives for academic credit at other institutions. The student is expected to graduate on (mm/dd/yy) _____.

Signature _____ Date _____ Name and Title of Official _____ School Seal/Stamp _____

For Office Use Only

Approved: _____ Date: _____

Immunization Record

(Canadian/U.S. Medical Students)

This form is to be completed by a **physician** or **nurse** only.
All titre tests and immunization records **must** be attached, a photocopy is acceptable.

Name: _____

Date of Birth: (mm/dd/yy) _____

Vaccine	Requirements	Major Indicators	Results
Measles, Mumps & Rubella	All students born after 1956 require a second MMR. If you are unable to have a second MMR, you must provide titres for Measles and Rubella.	In the past several years there have been significant outbreaks of measles, mumps and rubella in college students. Measles remains a serious disease with the risk of brain damage.	Date of 1 st MMR _____ Date of 2 nd MMR _____ Or Rubella titre – Reactive/Non-reactive Measles titre – Reactive/Non-reactive
Tetanus, Diphtheria Toxoid	All students must have documented proof of TD or Tdp in the past 10 years.		Date of last Td or Tdp _____
Polio Vaccine	Students should have at least one documented polio vaccine.		Date of last polio _____
Hepatitis B	If you have already had the vaccine, you must provide proof of immunity by having an Anti-Hbs test. Your level must be higher than 10 iu/ml.	Health care workers who will be repeatedly exposed to blood or blood products or to the risk of needle stick injury will be at risk for infection with the Hepatitis B virus.	Dates of vaccination 1 st _____ 2 nd _____ 3 rd _____ Anti Hb Level _____
TB Skin Test	Should be done in the last 12 months		<u>Date of 1st test</u> Mm of induration <u>Date of 2nd test</u> Mm of induration
Varicella	All students must show serological evidence of being immune to Varicella or they must get the vaccine. A history of the illness is not sufficient.	Because VZV is highly contagious and chicken pox may be life threatening for persons with immune deficiency states, all health care workers including students must be screened and vaccinated if required.	Date of Vaccine _____ Date of Vaccine _____ OR V Zoster Titre Reactive/Non Reactive

I verify the above information to be accurate:

Print Name of Physician/Nurse:

Signature of Physician/Nurse:

Date:
