

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.
- 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 1st 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.

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:

<u>Title (and # if known)</u>	<u>Location</u>
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 SHS Use UNSATIS	Only SATIS
		DATE	RESULT		
Rubeola: 1 ST dose must be after 1 st birthday	_____		*		
Rubella:	_____		*		
Mumps:	_____				
Varicella:	_____		*		
HepatitisB:	_____				
Dip/tet:					
Primary series	_____				
Booster (most recent must be within 10 years)	_____				
Polio:	_____				
PPD: 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 induration			
	_____ 1 st PPD date FOR SHS _____ 2 ^d PPD date USE ONLY	_____ mm induration			
		_____ mm induration			
CXR:	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