



**VISITING STUDENT ELECTIVE REGISTRATION FORM**

NAME \_\_\_\_\_ Sex Assigned at Birth \_\_\_\_\_

**Last**

**First**

**M.I.**

MEDICAL SCHOOL \_\_\_\_\_

PERMANENT ADDRESS \_\_\_\_\_ LOCAL ADDRESS \_\_\_\_\_

MOBILE NUMBER \_\_\_\_\_ NYU KERBEROS ID \_\_\_\_\_

NAME OF EMERGENCY CONTACT \_\_\_\_\_

ADDRESS OF EMERGENCY CONTACT \_\_\_\_\_

MOBILE NUMBER OF EMERGENCY CONTACT \_\_\_\_\_

**NEW YORK UNIVERSITY GROSSMAN SCHOOL OF MEDICINE REQUIRES ALL VISITING STUDENTS PARTICIPATING IN ELECTIVE PROGRAMS TO CARRY PERSONAL HEALTH INSURANCE. PLEASE COMPLETE THE INFORMATION BELOW.**

NAME OF INSURANCE CARRIER \_\_\_\_\_

GROUP OR CERTIFICATE NUMBER \_\_\_\_\_

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NAME OF ELECTIVE \_\_\_\_\_

DEPARTMENT \_\_\_\_\_

DATES OF ATTENDANCE \_\_\_\_\_

PRECEPTOR \_\_\_\_\_ HOSPITAL \_\_\_\_\_

**NEW YORK UNIVERSITY GROSSMAN SCHOOL OF MEDICINE REQUIRES ALL VISITING STUDENT ENROLLED IN ELECTIVES CARRY MALPRACTICE INSURANCE. THIS INSURANCE MAY BE PROVIDED BY EITHER YOUR MEDICAL SCHOOL OR THE INDIVIDUAL STUDENT. YOUR SIGNATURE BELOW INDICATES YOU ARE COVERED BY MALPRACTICE INSURANCE.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

CHECK/MONEY ORDER# \_\_\_\_\_

On the first day of your elective bring the completed form, and a check for the \$150 Registration Fee, to the Office of Registration & Student Records, 550 First Avenue, Medical Science Building, Room G-90.