

**VISITING STUDENTS-NON LCME
2008-2009 ACADEMIC YEAR**

STUDENTS ENROLLED IN NON-LCME SCHOOLS MUST REQUEST TO APPLY FOR VISITING STUDENT ELECTIVES AT NEW YORK UNIVERSITY SCHOOL OF MEDICINE. THIS FORM IS A REQUEST TO APPLY FOR ELECTIVES FOR THE 2008-2009 ACADEMIC YEAR (7/08 – 6/09) ONLY.

INSTRUCTIONS:

COMPLETE & SUBMIT THE VISITING STUDENTS – NON LCME ELECIVE REQUEST FORM DURING THE FOLLOWING PERIOD: APRIL 7, 2008 – May 23, 2008. DO NOT SUBMIT ANY ADDITIONAL DOCUMENTS.

THE REGISTRAR WILL RESPOND BY POSTAL MAIL AFTER NYU STUDENT ELECTIVE SCHEDULING IN MAY-JUNE 2008 IS COMPLETED. STUDENTS APPROVED TO APPLY WILL RECEIVE AN APPLICATION PROCEDURE OUTLINE.

SEND FORM BY POSTAL MAIL (FAX /E-MAIL NOT ACCEPTED)

**TO: MAUREEN DORAN, DIRECTOR
OFFICE OF REGISTRATION/STUDENT RECORDS
NYU SCHOOL OF MEDICINE - 550 FIRST AVENUE- NEW YORK, NY 10016 - USA**

THANK YOU FOR YOUR INTEREST IN OUR ELECTIVE PROGRAM.

VISITING STUDENTS – NON LCME ELECTIVE REQUEST FORM

TITLE: _____ FIRST _____ LAST _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ COUNTRY: _____

ZIP: _____ E-MAIL ADDRESS: _____

MEDICAL SCHOOL: _____ LOCATION: _____
country

REFERRED BY: _____

AT THE TIME OF THE ELECTIVE STUDENT WILL BE A _____YEAR STUDENT IN A _____YEAR PROGRAM. THE DATES STUDENT WILL HAVE COMPLETED THE FOLLOWING CORE CLERKSHIPS ARE INDICATED BELOW:

MEDICINE: _____ SURGERY: _____ OB/GYN: _____

PEDIATRICS: _____ PSYCHIATRY: _____ NEUROLOGY: _____

Check yes or no

yes no I WILL BE ABLE TO OBTAIN PROOF OF MALPRACTICE INSURANCE* (\$1 million per incident / \$3 million aggregate)

yes no I WILL BE ABLE TO OBTAIN PERSONAL HEALTH INSURANCE*

*New York University School of Medicine does not provide malpractice or personal health insurance coverage.

REQUESTED ELECTIVE(S)

ELECTIVE TITLE	DEPT	START – END DATE mm/dd/yr

STUDENT SIGNATURE: _____

DATE: _____

REGISTRATION USE ONLY

MD		HINS	
MINS		MCF	
APPS		SIS	
DTS		LOE	