VISITING MEDICAL STUDENT APPLICATION
International Medical Schools

OFFICE OF THE REGISTRAR
DUKE UNIVERSITY SCHOOL OF MEDICINE

Duke University School of Medicine
Room 0386, 3rd Floor
Seeley G Mudd Building
8 Searle Center Drive
Box 3878 DUMC
Durham, NC 27710

Scott Campbell, Student Services Officer
and Visiting Student Coordinator
scott.campbell@dm.duke.edu
Phone (919) 684-8042
FAX (919) 684-4322

(Return completed application and all supporting documentation **electronically** to the Visiting Student Coordinator at scott.campbell@dm.duke.edu)

Last Name, First Name, Middle Name (as it appears on current/valid passport):	Date (mm/dd/yyyy):
Date of Birth (mm/dd/yyyy):	Country of Citizenship:
Gender:	Contact Person for Home Medical School:
Ethnicity:	Contact Person email:
US SSN#(if applicable)	Home Medical School:
Current Mailing Address:	Home Medical School Mailing Address:
Telephone Number:	Home Medical School Telephone Number:
Fax Number:	Home Medical School Fax Number:

Elective(s) desired as listed in Duke School of Medicine Bulletin. Please list in order of preference.
Maximum of 8 weeks – **Must comply with Duke School of Medicine Academic / Elective Calendar dates**.

Course Department:	Course Number:	Course Title:	Dates of Course:

Statement of Home Medical School

The above named student is in good standing at this institution and is in the _____year of a _____ year program with an anticipated graduation date of (mm/dd/yyyy_____.

In addition, the student **will be in their final year of study and will have successfully completed** the required core clerkships in Medicine, Obstetrics & Gynecology, Pediatrics and Surgery (and any core rotation in the field in which they are applying for an elective) at the time of the requested elective. In addition, the student will receive academic credit at the home institution for work successfully completed. It is understood the visiting student is required to provide proof of completion of these clerkships upon arrival if approved and scheduled for an elective(s). Professional liability coverage is in effect while the student is away from the home institution for participation in this program. The amount of professional liability coverage to be provided, as stipulated in the approved affiliation agreement is:

$ _____ per occurrence / $ _____ aggregate.

As required, a copy of the Certificate of Coverage specifying these required limits must be provided. This institution and the student understand this is the only professional liability coverage she/he has while taking an elective at Duke University School of Medicine and must comply with Duke's professional liability coverage requirement **as stipulated in the approved affiliation agreement, whether coverage is to be provided directly by the school or directly by the student** . If approved for such an elective, the home institution, by signature of this application, agrees to provide and/or verify the required coverage.

Signature: Printed Name:

_____

Date: Title:

(School Seal) **Only original signature and seal accepted.**

Statement of the Visiting Medical Student

I am aware that acceptance as a Visiting Medical Student carries no implication concerning formal admission to or matriculation at Duke University School of Medicine. **Evaluation of my performance while studying at Duke University School of Medicine is based on the same criteria as those used to evaluate matriculated medical students at Duke. As such, only the Duke University School of Medicine Clinical Evaluation Form will be provided at the end of the approved elective period.**

If accepted, payment of the applicable registration fee, student health fee, and student medical insurance fee (applicable for all F1, J1, B1/B2 and WB visa holders) is required prior to my approved start date at Duke. This payment, payable to Duke University School of Medicine, is to be made directly to the Office of the Bursar. Applicable registration fee is based on effective date of the approved affiliation agreement on file. **$2200.00 one-time fee** for agreements approved prior to May 1, 2012, or **$6000.00 per scheduled elective** for agreements approved on/ after May 1, 2012.

Signature: Printed Name:

_____

Date (mm/dd/yyyy): home school email address: