

**VISITING STUDENT APPLICATION**  
**Office of the Registrar – Box 1257**  
**Mount Sinai School of Medicine**  
**One Gustave L. Levy Place New York, NY 10029**

Name \_\_\_\_\_ Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address \_\_\_\_\_ e-mail \_\_\_\_\_  
 \_\_\_\_\_ Phone \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_ Country City Number  
 \_\_\_\_\_  
 Citizenship \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Medical School \_\_\_\_\_ What Country? \_\_\_\_\_  
 I am currently a \_\_\_\_\_ year student in a \_\_\_\_\_ year program.

**This section to be filled out by Dean or comparable school official of medical school where the student is enrolled.**

The medical student above is in good standing at this institution. He/She \_\_\_\_\_ will \_\_\_\_\_ will not pay tuition at our institution during the period indicated below. Personal health coverage \_\_\_\_\_ is \_\_\_\_\_ is not in effect while the student is away from our school. Malpractice insurance \_\_\_\_\_ is \_\_\_\_\_ is not in effect while the student is attending the elective.

SCHOOL SEAL

\_\_\_\_\_  
 TITLE OF SCHOOL OFFICIAL Signature Date

**List Core Clerkships that you will have completed at the time of your proposed elective.**

Clerkship _____ - _____ Dates	Clerkship _____ - _____ Dates
Clerkship _____ - _____ Dates	Clerkship _____ - _____ Dates
Clerkship _____ - _____ Dates	Clerkship _____ - _____ Dates

**What elective are you applying for?**

If you are applying for more than one, Xerox appl., seal and reapply.

Note: All electives must begin on a Monday and end on a Friday.

Title of Elective \_\_\_\_\_ Elective Number \_\_\_\_\_ MSSM or Affiliate \_\_\_\_\_  
 Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (MONDAY) (FRIDAY)

**Non-refundable Processing Fee = \$100**  
**Mandatory Student Health Fee = \$40**  
**Payable by check or money order on**  
**First day of elective.**

**Return this form to:**

NAME OF DEPT.( INCLUDING INTERNAL BOX #)  
 Mount Sinai School of Medicine  
 One Gustave L. Levy Place; New York, NY 10029  
**IN ADVANCE of YOUR ARRIVAL (the**  
**Wednesday Prior), FAX THIS FORM TO THE**  
**VISITING STUDENT OFFICE 212/369-6013**

**FOR DEPARTMENT USE ONLY – DO NOT WRITE IN THIS SECTION**

The above elective \_\_\_\_\_ Has been approved for the requested time \_\_\_\_\_ is not available  
 \_\_\_\_\_ Is available for the following dates FROM \_\_\_\_\_ TO \_\_\_\_\_  
 Contact \_\_\_\_\_ at \_\_\_\_\_  
 Department contact person phone number

IF THE STUDENT HAS BEEN APPROVED TO TAKE THE ELECTIVE AND CANNOT ATTEND, **AT LEAST ONE MONTH'S NOTICE** MUST BE GIVEN SO THAT OTHER STUDENTS ON THE WAITING LIST CAN HAVE THE OPPORTUNITY TO PARTICIPATE IN OUR ELECTIVES PROGRAM.

**Proof of HIPAA compliance must be provided by the institution where you are matriculated. Otherwise, you will have to complete successfully HIPAA training at Mount Sinai.**