THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Office of International Medicine Programs

International Student Application for Clinical Electives at GWUMC

PART I:

Name: ______________________________________ Institution: _________________________

Date of Birth: ___________________Gender: __________ Citizenship: ___________________

Mailing Address: ____

Email Address: ____

Home Phone: __________________________ Cell Phone: _______________________________

Emergency Contact: ____________________ Relationship: ____________ Phone: __________

PART II:

Identify clinical departments and the course number you wish to participate in:
Use this link to choose: http://www.gwumc.edu/smhs/academic/medicine/electives/catalog.pdf

1- Course: ______________ Course Number: ___________ Start Date & Duration ______________

2- Course: ______________ Course Number: ___________ Start Date & Duration ______________

3- Course: ______________ Course Number: ___________ Start Date & Duration ______________

Total number of rotations requested __________ Total number of weeks requested: ___________

PART III:

****Only students from affiliated institutions may apply for electives at GWUMC****

School _______________________________________ Graduation Date _________________

This part must be completed by the Dean's Office of the applicant's school (Please affix school seal)
The above named student is registered in the MD/DO program. He/she is in good standing at the listed medical school and has permission to study within the GWU Elective system.

The student is ☐ is not ☐ covered by malpractice and liability insurance.
The student is ☐ is not ☐ covered by health insurance. If yes, enclose proof.
Prior to starting the elective(s), the student will have completed the following clerkships: medicine, surgery, obstetrics/gynecology, pediatrics and psychiatry. His/her overall academic standing is:
Excellent ☐ Good ☐ Solid ☐ Satisfactory ☐
Dean's Office Signature ____________________________________

2300 I Street, NW, Suite 708
Washington, DC 20037

Name and Title ____
Date ______________

Address where evaluation should be sent:
____

I ______________________________ certify that the following 3rd year core rotations have been completed by the above mentioned student so that he/she may participate in the International Clinical Electives Program. Please circle Yes or No. Transcripts must be attached for consideration.

Anesthesiology	YES	NO
Clinical Neuroscience	YES	NO
Emergency Medicine	YES	NO
Medicine and Subspecialties	YES	NO
Obstetrics and Gynecology	YES	NO
Pediatrics and Subspecialties	YES	NO
Psychiatry	YES	NO
Surgery and Surgical Specialties	YES	NO

PART IV:

Please rate your knowledge of languages (including English):

1st Language_______________________ ☐ Excellent ☐ Good ☐ Fair

2nd Language_______________________ ☐ Excellent ☐ Good ☐ Fair

3rd Language_______________________ ☐ Excellent ☐ Good ☐ Fair

Have you studied abroad before? Yes ☐ No ☐ If yes, please explain
____

PART V:
I understand that if my application for an International Clinical Rotation is approved, I am responsible for meeting all costs related to travel, lodging, and living expenses. I understand that I am responsible for obtaining my own visa and other necessary travel documents, immunizations, and other requirements as stipulated by the government of the United States.

I certify that the foregoing information is true and correct as stated.

Signature_________________________________ Date ______________________

Please submit the following with your application: Curriculum vitae; personal statement outlining goals and objectives; two letters of recommendation; letter of good standing, and academic transcripts.

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