



UNIVERSITY OF SOUTH ALABAMA
COLLEGE OF MEDICINE
Visiting Student Application

Section I: *To be completed by the Student and Dean's Offices of Student's Home School*

Name of Applicant _____ / _____ / _____
last m. first

Address: _____

City: _____ St: _____ Zip: _____

E-mail Address: _____ Phone (____) _____

Date of Birth: ____/____/____ Last 5 (not 4) of SS# _____

PARENT MEDICAL SCHOOL: _____

Contact Person: _____

School's Address: _____

City: _____ St: _____ Zip: _____

Title or Type of Elective Course You Wish To Take: _____

1st Choice Course # _____ (block-dates) _____

2nd Choice Course # _____ (block-dates) _____

3rd Choice Course # _____ (block-dates) _____

- I am applying for one 4 week rotation
- I am applying for two 4 week rotations (max 8 weeks)

Statement of Dean from Parent Medical School:

I certify the above named student is in good standing at the School of Medicine and has permission to study for credit at the University of South Alabama College of Medicine during the period listed above.

Signature, Dean/Associate Dean of Parent Medical School _____/_____/_____
Date

Print Name & Title: _____

Statement of the Visiting Medical Student:

I am aware of the following:

1. Evaluation of my performance while studying at the University of South Alabama College of Medicine will be based on the same criteria as those used to judge matriculated South Alabama students.
2. I am not covered by University of South Alabama health insurance and have provided a copy of my insurance card.
3. I have documented proof of Malpractice Insurance that meets the requirement of \$1 million per occurrence / \$3 million annual aggregate.
4. I have completed a program on universal precautions ensuring the appropriate handling of blood, tissues, and body fluids.
5. I have completed a program in Health Insurance Portability and Accountability ACT (HIPAA) ensuring the appropriate handling of protected health information.
6. I have completed and passed Step 1 USMLE and enclosed a copy.
7. I am requested to call as soon as possible if my situation changes and I am unable to take the indicated elective course.

Signature of Visiting Student

_____/_____/_____
Date

Print Name: _____

Upon completion of the form to this point, the potential visiting student should return it to:

Karen Braswell, Electives Coordinator
Student Affairs & Medical Education
University of South Alabama Medical Center
2451 Fillingim Street ~ Mastin 202
Mobile, AL 36617-2238
251-471-7145 ~251-470-5811 (fax)

Section II: to be completed at the University of South Alabama

Statement of the University of South Alabama College of Medicine Sponsor/ Department Chair:

I understand that there is an open student slot in the Elective Course this student has requested and I agree to sponsor and advise this visiting student during his or her visit to South Alabama. I understand that this student may not replace a South Alabama student in the above elective; i.e. more than the maximum number of students listed in the Elective Catalog cannot be scheduled.

Approved

NOT Approved

*Signature of Department Chair
(Required)*

_____/_____/_____
Date

After Section II is completed by department, please fax this page (2) only back to Karen Braswell at 251-470-5811 or e-mail at kbraswell@usouthal.edu