WAKE FOREST UNIVERSITY SCHOOL OF MEDICINE
APPLICATION FOR EXTRAMURAL CLERKSHIP

DIRECTIONS: Complete Sections I and II of this form. Supply the appropriate letters of recommendation (see Program Guide Electives). Complete the required health form. Enclose a check for the $50.00 non-refundable application fee (payable to Wake Forest University School of Medicine/Student Services). Return all documents to:

Wake Forest University School of Medicine
Office of Student Services, Medical Center Boulevard
Winston-Salem, NC 27157-1085

SECTION I To be completed BY APPLICANT.

Name _____ Social Security # _____

Telephone _____ _____ Mailing Address _____
(Day) (Night)
_____

CURRENTLY ENROLLED AS A _____ STUDENT E-MAIL_____
(Year)

CURRENTLY ENROLLED AT _____
(Name & Location of Medical School)

COURSE REQUESTED: _____ _____ ___/___/___ to __/___/___
Course # Course Name Dates

ALTERNATE COURSE: _____ _____ ___/___/___ to __/___/___
Course # Course Name Dates

SECTION II To be completed BY DEAN OF STUDENT SERVICES (or comparable official) of the medical school where student is enrolled.

The medical student named above will be a **fourth/final year** student as of (date) _____. He/She is a student in good standing at this institution and is applying for this elective with this school's permission. He/She **will____ will not____**pay tuition at our school during the period indicated. Malpractice insurance *(minimum requirement $1,000,000/$3,000,000)* **does____ does not____** cover the student away from our school. Personal health coverage **is____is not____** in effect away from our school. OSHA training is completed annually at our school **yes____ no____**. The student is approved to take this clerkship **for____ not for____**credit. At the conclusion of the clerkship, an evaluation report **will____ will not____**be required. A copy of the evaluation **is attached____ will be____** sent prior to the start of the rotation.

_____ _____ _____ _____
Signature Title Phone Date

*** PLEASE PLACE SCHOOL SEAL OVER THE OFFICIAL SIGNATURE ***

SECTION III APPROVAL (To be completed by the Registrar or the Associate Dean for Student Services of Wake Forest University School of Medicine).

STUDENT IS APPROVED FOR _____ _____
Course Name & Number Dates

Report to: _____ Date & Time: _____

Place: _____

_____ _____ _____
Signature Title Date

COPIES TO: STUDENT, WFU SCHOOL OF MEDICINE STUDENT SERVICES & WFU COURSE DIRECTOR

OSS/October 2003