



ELECTIVE APPLICATION FORM FOR INTERNATIONAL VISITING MEDICAL STUDENTS
Only 4 Months Allowed
(English Only)

PART 1: TO BE COMPLETED BY 4th YEAR APPLICANTS (Use separate form for each elective desired).

Applicant Name: _____

Class of: _____

Birth Date: _____

U.S. Citizen: **Yes** **No** (Please circle one. If no, complete foreign country.)

Foreign Country: _____

Mailing Address: _____

Telephone Number: _____

Email: _____

Medical School: _____

I am applying for a 4th Year Elective in: _____

1st Choice: _____ during the month of _____

2nd Choice: _____ during the month of _____

3rd Choice: _____ during the month of _____

I understand that Case Western Reserve University School of Medicine assumes no liability for any medical costs incurred by me while I am participating in an elective at that school. I agree to notify the Office of the Registrar, prior to my scheduled elective course dates, should I not be able to take the elective. I understand that confirmation of acceptance into any elective cannot be given until after CWRU students have been scheduled.

Signature of Applicant: _____ **Date:** _____