



**ELECTIVE APPLICATION FORM FOR VISITING MEDICAL STUDENTS**  
**Only 4 Months Allowed**

**PART 1: TO BE COMPLETED BY 4<sup>th</sup> 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 4<sup>th</sup> Year Elective in:** \_\_\_\_\_

**1<sup>st</sup> Choice:** \_\_\_\_\_ during the month of \_\_\_\_\_

**2<sup>nd</sup> Choice:** \_\_\_\_\_ during the month of \_\_\_\_\_

**3<sup>rd</sup> 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:** \_\_\_\_\_