



**ELECTIVE APPLICATION FOR VISITING MEDICAL STUDENTS**  
(A separate application must be completed for each elective requested.)

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**SECTION I: TO BE COMPLETED BY STUDENT.**

Student's Name \_\_\_\_\_  
Last First Middle

Mailing Address \_\_\_\_\_  
Street Address City/State/Country Zip Code

Date of Birth \_\_\_\_\_ Are you a U. S. citizen? \_\_\_\_\_ If NO, what country / Visa type? \_\_\_\_\_

Gender: ( ) Male ( ) Female Phone # \_\_\_\_\_ FAX # \_\_\_\_\_ E-Mail \_\_\_\_\_

Have you ever taken an elective at Baylor College of Medicine? (circle one) Yes No

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**Elective period requested** (NOTE: dates must correspond to the BCM academic calendar)

from (MM/DD/YY) \_\_\_\_\_ to (MM/DD/YY) \_\_\_\_\_.

List elective course numbers and titles in order of preference. For specific course numbers and descriptions refer to online listing at [www.bcm.tmc.edu/osa/](http://www.bcm.tmc.edu/osa/)

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

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**SECTION II: TO BE COMPLETED BY DEAN OR AUTHORIZED OFFICIAL OF STUDENT'S MEDICAL SCHOOL.**

- The applicant is a \_\_\_\_\_ year medical student in good standing at this institution and is authorized to take this elective.
- The student has completed all Basic Science courses required by this institution.
- Malpractice insurance (DOES) (DOES NOT) cover the student away from this school.
- The student (IS) (IS NOT) covered by health insurance.
- The student demonstrates proficiency in the English language.

List clinical prerequisites that will be completed by the start date of the elective:  
(Refer to elective catalog for prerequisites required for each course.)

- 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_
- 4) \_\_\_\_\_ 5) \_\_\_\_\_ 6) \_\_\_\_\_

As the Dean or authorized official of this student's home institution, I certify the above information to be correct and accurate.

\_\_\_\_\_  
NAME OF AUTHORIZED SCHOOL OFFICIAL (type or print) DATE

\_\_\_\_\_  
SIGNATURE TITLE

NAME OF SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_

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RETURN FORM TO:  
DONNA MOORE  
BAYLOR COLLEGE OF MEDICINE  
OFFICE OF THE REGISTRAR  
ONE BAYLOR PLAZA  
HOUSTON, TEXAS 77030