

Johns Hopkins University School of Medicine - Office of the Registrar  
733 N. Broadway, Suite 147, Broadway Research Building, Baltimore, Maryland 21205

**APPLICATION FOR CLINICAL ELECTIVE**

Electives are limited to one nine week period per academic year.

See website for complete listing of electives <http://www.hopkinsmedicine.org/som/students/academics/electives.html> .

Name(First, Last):		SSN:	
Birth Date(Month/Day/Year):	Telephone:		Gender (circle): Male/Female
Medical School:		Year in program:	
Anticipated year of graduation:		Citizenship:	
Mailing Address:			
E-mail Address:			
Name and Address of Emergency Contact Person:			
Elective Preference (list three): (Prerequisite: Completion of basic clerkship in elective specialty. Basic clerkship grade is required on official transcript)			
Dates of Elective:			

I am applying to the Department of Medicine Diversity Council Visiting Clerkship Program. (Financial Assistance) See the following website for more information <http://diversitycouncil.med.som.jhmi.edu/clerkship/index.html> .

I am applying to the Department of Otolaryngology-Head and Neck Surgery Diversity Committee Medical Student Mentoring Clerkship Program. (Financial Assistance) See the following website for more information [http://www.hopkinsmedicine.org/otolaryngology/education/medical\\_school\\_clerkship.html](http://www.hopkinsmedicine.org/otolaryngology/education/medical_school_clerkship.html)

This application should be returned to the Registrar's Office together with:

1. Letter of Good Standing
2. Immunization Form in confidential envelope
3. Official transcript of your record, sent directly by your medical school registrar
4. HIPAA Certifications... prior to registration visiting students must complete Johns Hopkins HIPAA training – see web site for further information: <http://www.hopkinsmedicine.org/som/students/policies/visitors.html> .
5. SHP Waiver Form

Additional information:

There is a \$300 registration fee per nine week quarter or any fraction thereof, payable at time of registration. The fee is not prorated. Visiting students are required to have U.S. based hospitalization insurance. Foreign insurance and travel insurance are not acceptable. Application for coverage in the School of Medicine insurance program can be made at the time of registration. The cost of health insurance is \$256 per month. Students from non-LCME accredited schools must pay a tuition fee of \$1,000 per nine week quarter or any fraction thereof.

A limited number of rooms are available in Reed Hall, the medical student residence for unmarried students. Visiting students are required to pay for their room and board. The fee is approximately \$500 per month and includes bedding and towels.

Please indicate if you wish to receive a housing application.

**Approval of Student's Medical School**

To be completed by Dean of Students or comparable official at medical school where the student is enrolled.

The medical student named above is in good standing at this institution. **She/He will/will not** pay tuition at our school during the period indicated. Malpractice insurance **does/does not** cover the student away from our school. Personal health coverage **is/is not** in effect while the student is away from our school. **She/He** is approved to take this elective **for credit/not for credit**. At the conclusion of the elective an evaluation report **will/will not** be required. If required, our evaluation form is attached; otherwise the JHUSOM evaluation form will be acceptable. Student **does/does not** require special accommodations. **If student requires special accommodations please describe in a separate document.**

Signature, Title and Institution:

Print Name of Official:

Send completed evaluation to following name and address: