



**THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE  
APPLICATION FOR FOURTH-YEAR ELECTIVES  
Visiting Students from Schools Accredited AOA**

(Print Legibly)

Last Name	First Name	E-mail/Internet Address
Mailing Address		Expected Graduation Date
Medical School		SSN
Phone ( )		Date of Birth

\*You must include documentation of immunizations

\* There is a \$75.00 non-refundable application fee. Please make checks payable to The Ohio State University

ELECTIVES REQUESTED (MAXIMUM OF TWO ELECTIVES OR 8 WEEKS TOTAL)		
	Name of Elective	Possible Dates (List in Preferred Order)
Elective #1		
Elective #2		
Alternate Choice		

**TO BE COMPLETED BY THE OFFICE OF YOUR DEAN**

The above student will have completed the following core clerkships at the time of requested rotation: (circle all that apply)

Internal Medicine - Pediatrics - OBGYN - Surgery  
Family Medicine - Psych - Neurology

The above student (circle yes or no):

YES	NO	Has passed Step 1 of the USMLE
YES	NO	Is in good academic standing
YES	NO	Is authorized by this school to take the elective and receive credit
YES	NO	Is covered by the school's malpractice insurance Minimum \$1,000,000 / incident and \$3,000,000 annual aggregate
YES	NO	Has personal health insurance coverage
YES	NO	Has the necessary immunizations including dTaP and PPD valid through end date of rotation
YES	NO	Has the student completed infection control procedure training?

Name of Dean or School Official  
(please print or type):

Title

Signature

(Place official school seal here)

**Return to:**

The Ohio State University, College of Medicine  
Med 3-4 & Visiting Student Program Office  
B013D Graves Hall  
333 W. 10<sup>th</sup> Avenue  
Columbus, Ohio 43210

E-mail: [visstu@osumc.edu](mailto:visstu@osumc.edu)  
Phone: 614-292-3525

**NOTE: EVALUATORS WILL USE THE STANDARD OHIO STATE PERFORMANCE  
EVALUATION FORM IF NO OTHER EVALUATION FORM IS RECEIVED.**

