University of Cincinnati College of Medicine (UCCOM)
Visiting Student Application

You may fill in form electronically then print OR print blank form then complete.
Saved forms will not retain entered information.

Section A: Personal Information (to be completed by the student)

Name of Applicant:

Social Security Number:

- ☐ Mr.
- ☐ Miss
- ☐ Mrs.

Mailing Address:

Street :

Apartment :

City:

State:

Zip:

Province:

Country:

Telephone:

Email Address:

Permanent Address:

☐ Same as Mailing Address

Street :

Apartment :

City:

State:

Zip:

Province:

Country:

Telephone:

Email Address:

Emergency Contact Name:

Emergency Contact Phone Number:

Medical School Attending:

Country of Medical School:

Address where clerkship verification/grade report should be sent:

Name:

Title:

Street:

Province:

Phone:

Institution:

City/State/Zip:

Country:

Signature of Student: _____

Date:

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Section B: Dean or Registrar Verification

This section **must** be completed by the Dean or Registrar of your medical school.
Requested information should be filled in legibly and/or appropriate responses checked below.

Name of Applicant: _____

Name of School: _____

Street Address: _____

City/State/Zip: _____

Province/Country: _____

Phone Number: _____

Standard length of time to complete MD program: _____ years: ____

Student's year of medical school: _____

Student's expected graduation date: _____

Student is approved to do electives: ☐ Yes ☐ No

Student is in good academic standing: ☐ Yes ☐ No

Student has **taken** and **passed*** United States Medical Licensing Examination (USMLE) Step 1: **If yes, Score:** ____ ☐ Yes ☐ No

Student will pay tuition at home school while away: ☐ Yes ☐ No

Student will be taking the clerkship for credit: ☐ Yes ☐ No

A written evaluation will be required at the end of course:** ☐ Yes ☐ No

Student will be covered by malpractice insurance coverage of $1,000,000 during rotation at UCCOM ☐ Yes ☐ No

Student is required to have personal health insurance while at his/her home school: ☐ Yes ☐ No

Student has received training in Occupational Safety and Health Administration (OSHA) standards regarding transmission of bloodborne and airborne pathogens: ☐ Yes ☐ No

If YES, please indicate date of training: ____

Student is fluent in English: ☐ Yes ☐ No

For international schools: Has student taken Test of English as a Foreign Language (TOEFL) exam? ☐ Yes ☐ No

If YES, please give score and date taken:

Score: ____ Date: ____

*Passing score in USMLE, Step 1 **required**

**Note: UCCOM faculty are not obligated to complete non-UCCOM evaluation forms.

To be completed by Dean or Registrar

Authorized by: _____ Date: _____

Signature

Name: _____ Title: _____

Print or type

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Section C: Clerkship Choices (to be completed by the student)

Visiting students are limited to a maximum of eight (8) weeks of clinical rotations. Please list below clerkship choice(s) and hospital site preference, if applicable. When possible, use specific course numbers.

UCCOM students will have first priority in elective rotation assignments.

Name of Applicant: _____

Maximum No. of Weeks desired: _____

	1st Choice	2nd Choice
Elective Title/Course Number:		
Rotation Dates:		
Course Director/Preceptor:		

Please attach a separate sheet for additional choices.

UCCOM Department approval:

Signature: _____ Date: _____

Name (type or print): _____ Phone: _____

Title: _____

Please return completed forms directly to the appropriate department chair using the department's address listed on the Visiting Students Web page.

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Section D: (To be completed by the UCCOM)

Department will submit all materials to the registrar for approval.

Student Name: _____

Medical School: _____

Admission of the above-named student to the elective and dates listed below

☐ Is approved. ☐ Is not approved.

The student will report to:

Elective: _____ Date: _____

Person: _____ Time _____

Place: _____

UCCOM Registrar's Signature:_____ Date: _____

☐ Complete application

☐ Transcript (for international students)

☐ Verification of health insurance

☐ Immunization records

☐ Fee (for international students)

☐ Fee for Blood-borne Pathogen insurance policy for UC

Departments please mail completed forms to:
Incomplete applications will not be processed.

Registrar
University of Cincinnati College of Medicine
P.O. Box 670552
231 Albert Sabin Way
Cincinnati,OH 45267-0552
Telephone: (513) 558-5575

Print Form

Department Addresses for Visiting Student Application

Unless otherwise noted (*), please address applications to:

Department Name
PO Box Number
University of Cincinnati
College of Medicine
Cincinnati, OH 45267

Anesthesia
PO Box 670531

Cell Biology, Neurobiology and Anatomy
PO Box 670521

Dermatology
PO Box 670592

Emergency Medicine
PO Box 670769

Environmental Health
c/o Registrar
Office of Student Affairs
PO Box 670552

Family Medicine
PO Box 670582

Hoxworth Blood Center
PO Box 670055

Internal Medicine
PO Box 670534

Molecular and Cellular Physiology
PO Box 670576

Molecular Genetics, Biochemistry and Microbiology
PO Box 670524

Multidisciplinary Electives (23-03)
c/o Registrar
Office of Student Affairs
PO Box 670552

Neurology
PO Box 670525

Neurosurgery
PO Box 670515

Ob/Gyn
PO Box 670526

Ophthalmology
PO Box 670527

Orthopaedics
PO Box 670212

Otolaryngology
PO Box 670528

P M & R
PO Box 670530

Pathology
PO Box 607529

Pediatrics*
3009 Medical Student Education
CCHMC
BN5.553
3333 Burnet Ave.
Cincinnati, OH 45229

Psychiatry
PO Box 670559

Radiology
PO Box 670761

Surgery
PO Box 670558