

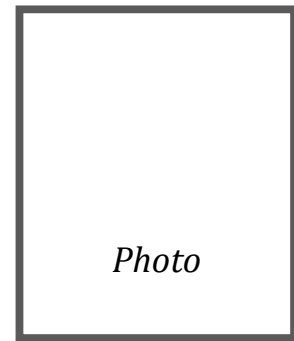


# Facultad de **MEDICINA**

**UNIVERSIDAD FRANCISCO MARROQUÍN  
SCHOOL OF MEDICINE  
APPLICATION FOR  
EXCHANGE CLERKSHIP IN  
THE RURAL PRACTICE PROGRAM**

FOR OFFICIAL USE ONLY	
Month :	_____
Fee:	_____
Section 1 of form:	_____
Section 2 of form:	_____
Section 3 of form:	_____
Emergency Information:	_____
Health Information:	_____
Insurance Information:	_____

**Complete and return application to (if by e-mail):**  
**Oficina de Asuntos Académico**  
**Universidad Francisco Marroquín**  
**Section 188 P.O.Box 02-5289**  
**Miami, FL 33102-5289 or**  
[medicina@ufm.edu](mailto:medicina@ufm.edu)



**SECTION 1: To be completed by the student. Please print or type.**

<b>Name</b>	Last:	First:	Middle:
<b>Birth Date</b>	Day:	Month:	Year:
<b>Mailing Address</b>	Street:		City:
	State:	Country:	Zip Code:
<b>Permanent Address</b>	Street:		City:
	State:	Country:	Zip Code:
<b>Telephone</b>	(Please include area code).		
<b>Email Address</b>			
<b>Medical School</b>	Name:		
	Address:		Telephone:
<b>Emergency Contact Health</b>	Expected Degree:		Date:
	Name:		Telephone:
	Known diseases:		



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<b>Information</b>	Treatments use at the moment:		
	Important allergies (specify symptoms):		
	Vaccination History:		
	___ TB SKIN TEST (PPD): <b>Within past 12-month period.</b> Date: ___/___/___ Neg. ___ Pos ___ *If above test positive, a chest x-ray is required. Date: ___/___/___ Results ___		
	___ TETANUS/DIPHTHERIA: Primary series plus Td booster within the last 10 years. Td booster Date: ___/___/___		
	___ MMR: (Measles, Mumps, Rubella):		
		Vaccine	or Positive Serology
		Date: Mumps ___/___/___	___/___/___
		Date: Rubella ___/___/___	___/___/___
		Date: Measles ___/___/___	___/___/___
	___ HEPATITIS B: Series of three doses: Dates 1.) ___/___/___ 2.) ___/___/___ 3.) ___/___/___		
	HAS THE STUDENT HAD Chickenpox (Varicella)? ___ YES ___ NO* If YES, at what age? ___ *IF NO: A Varicella antibody test must be done. If this test shows no immunity 2 doses of chickenpox vaccine must be given 4-8 weeks apart.		
	Chicken pox Vaccine	1st Dose ___/___/___ 2nd Dose ___/___/___	
<b>Health Care Provider</b>	Name:	Telephone:	
	Signature:	Date:	

**Please read this BEFORE completing application form:**

UFM Medical School requires all visiting students requesting enrollment in our clinical electives show proof of a TB test, immunity to measles, mumps and rubella, tetanus/diphtheria, and hepatitis B.

Applicants must be free from symptoms of infectious disease at the start of the elective. Should you become ill with a communicable disease during enrollment, you are **REQUIRED** to notify your course director/attending physician and remove yourself from patient care activity.



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The student must be covered with personal health insurance (attach proof) which covers the student while away from school.

Is preferred if student have completed all required core clerkships to apply, including Internal Medicine, Surgery, Obstetric/Gynecology and Pediatrics; but is not a requirement. It's also not a requirement to speak Spanish. Visiting students are limited to a maximum of three months clerkship. Grade reports will be sent to your school. Information of Medical School must be provided.

A non-refundable fee of \$150 per month must accompany this application. Variations on clerkship dates are not possible. We must have your complete application at least 60 days in advance of the clerkship start date but no earlier than 6 months prior to the start date.

<b>SECTION 2: To be completed by the student. Please print or type.</b>		
<b>Elective Dates</b>	From:	To:
<b>Speak Spanish?</b>	Yes:	No:
<b>Special request or comments:</b>		

I have read and understand all the application materials. I understand that the application materials submitted become the property of UFM Medical School. I also attest that the information given in this application to be accurate and true. In addition, if accepted and enrolled I:

1. Understand I remain a student in my home school and that the ultimate responsibility for patient care resides with the School of Medicine of UFM.
2. Will respect the confidential nature of all medical records and personally identifiable information related to patients.
3. Will act prudently within the limits of my knowledge, experience and training; follow policies related to procedures and etiquette; and wear attire acceptable by the University.
4. Shall respect all property belonging to the University and its affiliates institutions and I understand that my home school will be responsible to repair or replace any property damaged or destroyed by me.

<b>Student's Signature</b>	<b>Date:</b>
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**SECTION 3: To be completed by the authorized Dean or Registry Office Oficial at the student's Medical School. Please print or type.**

<b>Medical School</b>	Name:	
	Address:	Telephone:
<b>Dean or School Oficial</b>	Name:	Title:
	Email address:	Telephone:
<b>Comments about the student applying</b>		

As school oficial I attest that the information given by the student named above is in good standing at this institution and the information in this application is to be accurate and true, and he/she have our permission to enroll for clinical electives.

<b>Authorized by (Signature):</b>	<b>Date:</b>
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