Facultad *de*
MEDICINA

FOR OFFICIAL USE ONLY

Month :_____
Fee: _____
Section 1 of form: _____
Section 2 of form: _____
Section 3 of form: _____
Emergency Information: _____
Health Information: _____
Insurance Information: _____

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

Photo

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

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

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

UFM Facultad de MEDICINA

Information		
	Treatments use at the moment:	
	Important alegies (specify symtoms):	
	Vacctination History: ____ TB SKIN TEST (PPD): **Within past 12-month period**. 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 ____/____/____	
Health Care Provider	Name:	Telephone:
	Signature:	Date:

<u>Please read this BEFORE completing application form</u>:
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 <u>REQUIRED</u> to notify your course director/attending physician and remove yourself from patient care activity.

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

Is preferred if student hase completed all required core clerships to apply, including Internal Medicine, Surgery, Obstectric/Gynocology 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.

SECTION 2: **To be completed by the student. Please print or type.**		
Elective Dates	From:	To:
Speak spanish?	Yes:	No:
Special request or comments:		

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 properrty damaged or destroyed by me.

Student's Signature	**Date:**

Facultad *de*
MEDICINA

SECTION 3: To be completed by the authorized Dean or Registry Office Oficial at the student's Medical School. Please print or type.		
Medical School	Name:	
	Address:	Telephone:
Dean or School Oficial	Name:	Title:
Contact Information	Email address:	Telephone:
Comments about the student applying		

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.

Authorized by (Signature):	**Date:**