Chiba University School of Medicine

VISITING MEDICAL STUDENT APPLICATION FOR ELECTIVE COURSES IN CHIBA

PART I. TO BE COMPLETED BY THE VISITING STUDENT

PHOTO
Paste here

1. NAME (print legibly):_____
Last (Family) Name First

Date of Birth:_____/ _____/ _____
Year Month Date

2. Permanent Address: _____
House Number Street Apartment/Suite #

_____
City State/Province Zip/Postal Code Country

Telephone #:_____ Fax #:_____

E-Mail: _____@_____

Skype ID:_____

3. CONTACT PERSON IN CASE OF EMERGENCY _____

4. OBJECTIVE (Research / Observation / Lecture / Clinical Clerkship Elective)

5. INTENDED PERIOD

Begin Date:	End Date:	Weeks		Begin Date:	End Date:	Weeks
_____/ _____/ _____	_____/ _____/ _____	_____w	(and/or)	_____/ _____/ _____	_____/ _____/ _____	_____w

6. PREFERENCE OF DEPARTMENTS(3 choices)

1st _____ 2nd _____ 3rd _____

(Japanese Ability: fluently / Beginner / Little / None)

☐I have read and signed a Confidentiality agreement at Chiba University Hospital.

Signature: _____ Date Signed: _____

PART II. TO BE COMPLETED BY THE DEAN OR DESIGNEE OF VISITING STUDENT'S MEDICAL SCHOOL

1. The student will be registered in his/her (1st 2nd 3rd 4th 5th 6th) year during the proposed elective.

2. School will attach evidence of student's liability insurance coverage? (Yes / No)

3. School will attach evidence of student's personal health coverage? (Yes / No)

4. Assessment of academic ability: (Above Average / Average / Below Average)
Assessment of clinical ability: (Above Average / Average / Below Average)

5. have completed the required clerkships: Medicine, Pediatrics, Psychiatry, Surgery, OB/Gyne ***prior*** to this elective? (Yes / No)
Other experienced clerkships if any: _____

6. Your evaluation form will be (Attached / Sent later / Brought by students / Complied with Chiba Evaluation form / Not necessary)

7. Return Evaluation to be sent to (by mail @ _____ or

by EMS to _____
Faculty Name & Title **Address** **City** **State** **Zip Code**

Signature: _____

Date Signed: _____

(print) _____
First and Last Name

School seal or stamp

_____
Title

Please return complete application to:
International Affairs & Public Relations
School of Medicine Chiba University
1-8-1 Inohana, Chuo-ku Chiba 260-8670 Japan