



Chiba University School of Medicine

VISITING MEDICAL STUDENT APPLICATION FOR ELECTIVE COURSES IN CHIBA

PART I. TO BE COMPLETED BY THE VISITING STUDENT

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

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

_____ City State/Province Zip/Postal Code Country

Telephone #: _____ Fax #: _____

E-Mail: _____ @ _____



3. CONTACT PERSON IN CASE OF EMERGENCY _____

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

5. INTENDED PERIOD STATE YOUR PREFERENCE OF DEPARTMENT

Begin Date: _____ End Date: _____ Weeks _____

(Monday) (Saturday)

_____ w _____

_____ w _____

(Japanese Ability: Speak fluently / Beginner / Little / Never learned)

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

- The student will be registered in his/her (1st 2nd 3rd 4th 5th 6th) year during the proposed elective.
- School will attach evidence of student's liability insurance coverage? (Yes / No)
- School will attach evidence of student's personal health coverage? (Yes / No)
- Assessment of academic ability: (Above Average / Average / Below Average)
 Assessment of clinical ability: (Above Average / Average / Below Average)
- have completed the required clerkships: Medicine, Pediatrics, Psychiatry, Surgery, OB/Gyne **prior** to this elective? (Yes / No)
- Your evaluation form will be (Attached / Sent later / Brought by students / Complied with Chiba Evaluation form / Not necessary)
- Return Evaluation to be sent to (by mail @ _____ or _____

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

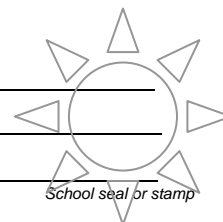
Signature: _____

Date Signed: _____

(print) _____

First and Last Name

Title



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