LEWIS KATZ SCHOOL OF MEDICINE AT TEMPLE UNIVERSITY
INSTRUCTIONS AND CHECKLIST FOR VISITING STUDENTS

Please Use This Checklist to Ensure That Your Application Will Be Complete.
Only Complete Applications Will Be Reviewed.

TO BE ELIGIBLE STUDENTS MUST:

☐ 1. Currently be in good standing at an LCME or AOA accredited medical school, or at a medical school having a formal affiliation with Temple University School of Medicine.
☐ 2. At the time of the elective, be in the fourth year of medical school, or in the curricular year which presupposes completion of all core clinical clerkships.
☐ 3. Submit verification of completion of core clerkships in each of the following disciplines, indicating the number of weeks devoted to each (minimum requirement of 4-8 weeks before you can start your rotation here at the LKSOM at Temple University): Family Medicine/Primary Care, General Internal Medicine, Obstetrics/Gynecology, Pediatrics, Psychiatry, and General Surgery. (see application).

ATTACH THE FOLLOWING DOCUMENTATION:

☐ 4. Proof of Medical liability/malpractice insurance coverage.
☐ 5. Proof of Personal health insurance coverage.
☐ 6. Proof that Immunizations (please use Temple form) are current and complete.
☐ 7. Blood borne/Airborne pathogens training has been completed during the current academic year.
☐ 8. Curriculum Vitae

ATTACH THE FOLLOWING DOCUMENTATION IF APPLYING TO EMERGENCY MEDICINE:

☐ 10. Transcript (official)
☐ 11. USMLE Step 1 Score Report

YOU SHOULD KNOW:

- Visiting student applications will be accepted after March 1 for the following academic year.
- Visiting students may be approved for a maximum of two 4-week rotations.
- All documentation supporting the application must contain original signatures and the school seal. Photocopies/faxes will not be accepted.
- Temple does not provide housing. Click here for suggested housing options in our area.
- Parking is available for a fee. For more information, visit www.temple.edu/parking/hsc.html.

Upon completion, please scan your application to emjohn@temple.edu, and then mail the original application to:
Temple University School of Medicine, Office of Academic Affiliations, 3500 N. Broad St., Suite 325, Philadelphia, PA 19140
LEWIS KATZ SCHOOL OF MEDICINE AT TEMPLE UNIVERSITY
VISITING MEDICAL STUDENT APPLICATION FOR ELECTIVE ROTATION(S)

SECTION I: TO BE COMPLETED BY APPLICANT

Name

First

Last

Male

Female

Phone

Address

Email Address

Birth Date

Mo

Day

Year

Alternate Email Address

Graduation Date

Mo

Day

Year

Name of Medical School

Address of Medical School

Country

Phone

Fax

Web Address

I wish to apply for one or two rotation(s).

Courses in order of preference are:

1) _______________________________
   Course ID# ______________________

2) _______________________________
   Course ID# ______________________

3) _______________________________
   Course ID# ______________________

In order of preference, I wish to be scheduled for Temple Blocks or ; I am available only:

From

Mo

Day

Year

Through

Mo

Day

Year

Signature ____________________________ Date ____________________________
LEWIS KATZ SCHOOL OF MEDICINE AT TEMPLE UNIVERSITY
VISITING MEDICAL STUDENT APPLICATION FOR ELECTIVE ROTATION(S)

Name of Applicant: ______________________ ______________________
First Last

SECTION II: TO BE COMPLETED BY DEAN’S OFFICE OF APPLICANT’S SCHOOL:

Please check the appropriate responses to certify that student:

☐ 1. Has completed the core clerkships listed below. (Proof of completed core clerkships will accompany the application. I verify that I understand this is required before I can start my rotation).

☐ 2. Is in good standing at this institution.

☐ 3. Has permission to take the above listed course(s) for elective credit.

☐ 4. Has malpractice insurance that will cover them while at TUSM.

☐ 5. Has personal health insurance that will cover them while at TUSM.

☐ 6. Has completed blood borne and airborne pathogens training during the last 12 months.

☐ 7. Has successfully passed a criminal background check within the last 12 months.

Family Practice (min 4 wks) □ wks
Pediatrics (min 6-8 wks) □ wks
Internal Medicine (min 6-8 wks) □ wks
General Surgery (min 6-8 wks) □ wks
OB/Gyn (min 6-8 wks) □ wks
Psychiatry (min 4 wks) □ wks

Other ____________________________

Name of Dean ____________________________ Title ____________________________
(Or Dean’s Office Representative)

Signature ____________________________ Date ____________________________

Seal ____________________________ Email ____________________________
(Must cover signature)
Phone ____________________________