**Gilbert and Rose-Marie Chagoury School of Medicine**

**Place recent colored passport-size photo**

**Byblos Campus**

**P. O. Box: 36-Byblos**

**Lebanon**

**Tel: +961 9 547 262**

**+961 3 791 314**

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**Visiting Medical Student Application for Clinical Elective**

**Part I:** *to be completed by the visiting student*

|  |  |  |
| --- | --- | --- |
| Last Name: | First Name: | Middle Name/Initial: |

|  |  |
| --- | --- |
| Elective choice: *List up to three choices* | |
| Choice | Date  (From/To) |
|  |  |
|  |  |
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| --- | --- | --- | --- | --- |
| Education: *List all clerkships that you completed or you expect to complete before joining the elective* | | | | |
| Clerkship | Number of Weeks | University | Hospital | Date |
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| --- | --- | --- | --- |
| Language proficiency: *Rate your knowledge of languages* | | | |
| 1st language: | *Excellent* ☐ | *Good* ☐ | *Fair* ☐ |
| 2nd language: | *Excellent* ☐ | *Good* ☐ | *Fair* ☐ |
| 3rd language: | *Excellent* ☐ | *Good* ☐ | *Fair* ☐ |

I undersigned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify that the information disclosed on this application is true and correct.

Student ‘s Signature

**Part II:** *to be completed by the Dean’s Office of the visiting student*

The above named student is a registered full time student in good standing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The student is presently in her/his \_\_\_\_\_\_\_\_ year of a \_\_\_\_\_\_\_\_ year program studying for the M.D. degree. The student has the permission to take the requested elective during the periods listed. This student will\_\_\_ will not\_\_\_\_ pay tuition at our Faculty during the period of elective. The personal health coverage is\_\_\_ is not\_\_\_ in effect while the student is away from our Faculty. Malpractice insurance covers\_\_\_ does not cover\_\_\_\_ the student away from our faculty. Academic credits will\_\_\_ will not\_\_\_ be awarded upon receipt of a passing grade. An evaluation of the student’s performance will\_\_\_ will not\_\_\_ be required *(if a special form of evaluation is required please enclose one).*

|  |  |  |
| --- | --- | --- |
| School Seal | Signature |  |
| Name |  |
| Title |  |
| Date |  |

**Part III:** *to be completed by the program accommodating the visiting student*

This application is approved \_\_\_\_\_/ not approved \_\_\_\_\_. The student should report to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_), on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of the Dean or designee:

**Information to the applicant**

The student should provide the Dean’s Office with the following:

1. One recent passport-size photo
2. A photocopy of the identity card or passport
3. An updates CV
4. Medical School transcript
5. A letter of good standing
6. A letter of recommendation from the Dean’s Office including information regarding clinical clerkships that were completed or are in progress
7. A completed LAU visiting students immunization form along with proof of vaccination/lab reports
8. Medical Health Insurance coverage
9. Liability Insurance coverage (in case of clinical elective)
10. Drug Screen Test (for international applicants)

The application with the above supporting documents (a CV is optional) should be sent by email to Mrs. Micheline Chaar:

Email: [micheline.chaar@lau.edu.lb](mailto:micheline.chaar@lau.edu.lb)

Tel: +961 1 200800 Ext. 5847