



**MEMORIAL SLOAN-KETTERING CANCER CENTER
APPLICATION FOR FINAL YEAR ELECTIVE STUDY
MEDICAL STUDENTS FROM INTERNATIONAL MEDICAL SCHOOLS**

TO BE COMPLETED BY MEDICAL STUDENT

Student Name: _____

Student Mailing Address: _____

Student Telephone Number: _____ Student E-mail Address: (Print) _____

Medical School and Mailing Address: _____

Medical School Telephone Number: _____

ELECTIVE REQUESTS

Elective Request	Module Dates		Alternate Elective	Alternate Dates

TO BE COMPLETED BY DEAN (OR AUTHORIZED OFFICIAL) OF MEDICAL SCHOOL

This student is presently in his/her _____ year of a _____ year program, studying for an MD (or equivalent) degree.

1. **YES** **NO** The above-named student is in **GOOD STANDING** at this institution.
2. **YES** **NO** The above-named student will be a **FINAL** year student at the time of the elective.
3. **YES** **NO** The student is approved to take this elective **FOR CREDIT**.
4. **YES** **NO** Personal health coverage **IS** in effect during the elective while the student is away from school.
5. **YES** **NO** Malpractice insurance **IS** in effect during the elective while the student is away from school.

Answers to Items 1, 2, & 3 must be **YES** in order for the student to be eligible for the MSKCC Elective Program.

If answers to items 4 & 5 are **NO**, student must provide proof of health and malpractice insurance coverage during elective.

ATTENTION: Dean (Or Authorized Official) of Medical School **School Seal/Stamp**

Signature/Title: _____

Print Name/Title: _____

E-Mail Address: _____

Date: _____

Return completed application to: Medical Student Coordinator, Memorial Sloan-Kettering Cancer Center, Graduate Medical Education, Box 187, 1275 York Avenue, New York, New York 10065 (Phone Number: 212-639-3359)