MEMORIAL SLOAN KETTERING CANCER CENTER

APPLICATION FOR FINAL-YEAR ELECTIVE PROGRAM

1275 York Avenue, Box 187, New York, New York 10065

TO BE COMPLETED BY MEDICAL STUDENT

Student Name: _____

Student Mailing Address: _____

Student Telephone Number: _____ Student E-mail Address: _____

Medical School Name and Mailing Address: _____

_____

Medical School Telephone Number: _____

ELECTIVE REQUESTS

Please circle: I am applying for **1** or **2** elective(s).

Requested Module Dates for First Elective: _____

Requested Module Dates for Second Elective (if applicable): _____

Please list your elective choices below.

First Choice Elective: _____ Third Choice Elective: _____

Second Choice Elective: _____ Fourth Choice Elective: _____

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

Student is currenty in his/her_____ year of a _____year program, studying for an MD (or equivalent) degree.
This student is expected to graduate in the month of _____, year _____.

1. **YES NO** The above-named student is in **GOOD STANDING** at this institution.
2. **YES NO** The above-named student will be in their **FINAL 12 months** at the time of their elective(s).
3. **YES NO** The above-named student is approved to take this/these elective(s) **FOR CREDIT**.
4. **YES NO** Personal health coverage **IS** in effect while the student is away from school.
5. **YES NO** Malpractice insurance **IS** in effect while the student is away from school.

If answers to 4 & 5 are NO, upon acceptance, the student must provide proof of health and malpractice insurance.

ATTENTION: Dean or Authorized Medical School Official

Signature/Title: _____

SCHOOL SEAL/STAMP

Print Name/Title: _____

E-Mail Address: _____

Date: _____