



**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)**