



Medical College of Georgia School of Medicine
Augusta, Georgia

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VISITING STUDENT ELECTIVE APPLICATION

PART II: To be completed by the Dean of the student's school and sent in WITH the application (MUST HAVE ORIGINAL FORM)

_____ has applied for an
Student's Name

elective(s) at the Medical College of Georgia. I certify that the following information is accurate.

He/she is a 4th year student (**at time of elective**) and has completed all required clerkships.

He/she has completed immunization requirements

He/she has successfully completed HIPAA and OSHA training

He/she has completed CPR training

He/she has passed USMLE Step I/ COMLEX.

TB (PPD) Skin Test (**must be current at time of elective, results must accompany application, if possible**)

He/she has had a criminal background check

He/she has malpractice insurance coverage

He/she has health insurance coverage

An evaluation is required: Yes No. (**If a form is used please attach a copy and provide a return address**)

Signature _____ Date _____

Printed name and title

School's Seal (REQUIRED)