



ELECTIVE APPLICATION FORM- Osteopathic 2010-2011 (Effective 1/26/2010)

A. To Be Completed By The Student:

Name (please print): _____ Class of: _____
Expected graduation date: _____ (month/year) DOB: _____
Mailing Address: _____
E-Mail Address: _____ Phone: _____

Elective Requested

Course Elective Dates 1st Choice from: _____ to: _____
2nd Choice from: _____ to: _____

The following requirements are MANDATORY

- ◆ Proof of vaccination for measles and rubella (since 1980).
◆ Recent results of TB test (within 6 months of elective start date) or chest x-ray, if skin test is positive.
◆ Documentation of Hepatitis B vaccination or a signed declination form.
◆ Proof of health insurance (photocopy of insurance card).
◆ \$125.00 non-refundable fee per elective (payable to: The University of Arizona).
◆ HIPAA – Post Test and SIGNED Confidentiality Agreement

B. To Be Completed By The Dean of Students or Contact Person of Your School:

- 1. Will the student pay tuition at your school during the time period listed above? [] Y [] N
2. Is the student approved to take this elective for credit? [] Y [] N
3. Will the student have passed all of the core clerkships by the start of this elective? [] Y [] N
4. Will an evaluation form be required at the end of the elective? Please provide. [] Y [] N
5. Has completed the OSHA requirement for training in the prevention of transmission of bloodborne pathogens? [] Y [] N
6. Student must be covered by general/professional liability insurance in the amounts of \$1 million per claim and \$3 million aggregate during this elective.

A copy of the current certificate indicating policy amounts or a letter from your school indicating policy amounts must accompany this application. If not, it must be sent one month prior to the elective starting date.

Name of Official (printed) _____ Title _____
Signature of Official _____ Date _____
(SEAL)

Medical School and Address: _____

Fax #: _____

C. To Be Completed by the Elective Coordinator:

Student request is: Is Approved Is NOT Approved

The student will report to:

Contact: _____ Start Date: _____ Start Time: _____

Address of Contact: _____ e-mail: _____

Coordinator's Signature: _____ Phone: () _____

D. To Be Completed by the Student Records Office:

The elective requested: Is Available Is NOT Available

Signature: _____

Title: _____ Date: _____

Mail completed application, required documents and application fee \$125.00 to:

**The University of Arizona
College of Medicine–Phoenix
in partnership with Arizona State University
550 E. Van Buren St.
Phoenix, AZ 85004**

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klynch1@email.arizona.edu**