

## ELECTIVE APPLICATION FORM – Osteopathic Students 2011-2012 (Effective 1/26/11)

### 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	1 <sup>st</sup> Choice	from: _____	to: _____
	2 <sup>nd</sup> Choice	from: _____	to: _____

### The following requirements are **MANDATORY**

- ◆ Proof of vaccination for measles and rubella (*since 1980*).
- ◆ Recent results of TB test (*within 1 year 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 – available on our website

### 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 of \$125.00 to:**

**The University of Arizona  
College of Medicine  
Student Records Office  
P.O. Box 245026  
Tucson, AZ 85724-5026  
Fax: (520) 626-8571 | Office Phone: (520) 626-2526  
[visiting@email.arizona.edu](mailto:visiting@email.arizona.edu)**