VISITING STUDENT ELECTIVE REGISTRATION FORM
Academic Year 2017-2018

NAME:_______________________________________________________________________

Last    First     M.I.

MEDICAL SCHOOL:___________________________________________________________

PERM. ADDRESS:______________________________  LOCAL ADDRESS:____________________

______________________________   _____________________

PERM. TELEPHONE:____________________________ LOCAL TELEPHONE:___________________

PERSON TO CONTACT IN EMERGENCY:_____________________________________________

EMERGENCY CONTACT ADDRESS:__________________________________________________

EMERGENCY CONTACT TELEPHONE NUMBER:________________________________________

NEW YORK UNIVERSITY SCHOOL OF MEDICINE REQUIRES ALL VISITING STUDENTS
PARTICIPATING IN ELECTIVE PROGRAMS TO CARRY PERSONAL HEALTH INSURANCE.
PLEASE COMPLETE THE INFORMATION BELOW.

NAME: OF INSURANCE CARRIER:____________________________________________________

GROUP OR CERTIFICATE NUMBER:____________________________ ______________________

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ELECTIVE TITLE:____________________________________________ _________________________

DEPARTMENT:_________________________________________________________ ______________

INCLUSIVE DATES:___________________________________________________________________

PRECEPTOR:__________________________________  HOSPITAL:____________________________

NEW YORK UNIVERSITY SCHOOL OF MEDICINE REQUIRES ALL VISITING STUDENT
ENROLLED IN ELECTIVES CARRY MALPRACTICE INSURANCE. THIS INSURANCE MAY BE
PROVIDED BY THE MEDICAL SCHOOL OR THE INDIVIDUAL STUDENT. YOUR SIGNATURE
BELOW INDICATES YOU ARE COVERED BY MALPRACTICE INSURANCE.

SIGNATURE:__________________________________  DATE:________________________________

Amount: $125.00

CHECK/RECEIPT #__________________________

registr.doc

Form must be submitted in person to: Registration & Student Records, 545 1st Avenue, Floor 6, Suite 6M, NY, NY 10016.

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