Chiba University School of Medicine

**VISITING MEDICAL STUDENT APPLICATION FORM**

**PART1. TO BE COMPLETED BY THE VISITING STUDENT**

1. Name:

PHOTO

Paste here

　　　　　　　 Last (Family) Name First Name

2. Date of Birth: / /

 Year Month Date

3. Address:

 House # Street Apartment/Suite #

 City State/Province Zip/Postal Code Country

 Tel: Email:

4. Contact person in case of emergency:

Tel: Email:

5. Objective ( □RESERCH / □OBSERVATION / □LECTURE / □CLINICAL CLERKSHIP )

6. Intended Period

 Begin date: / / End date: / / weeks (□AND / □OR)

Begin date: / / End date: / / weeks

7. Preference of departments (3 choices)

 1) 2) 3)

 ( Japanese ability: □FLUENTLY / □BEGINNER / □LITTLE / □NONE )

8. Confidentiality agreement

 □I have read and signed a Confidentiality agreement at Chiba University Hospital.

Signature: Date:

9. Other special notes: If there is anything you would like us to know in advance,

（Eating Habits,/Allergies, Religion, Physical Characteristics and Health condition, etc…)

**PART2. TO BE COMPLETED BY THE DEAN OR DESIGNEE OF VISITNG STUDENT’S MEDICAL SCHOOL**

1. The student will be registered in his / her ( 1st / 2nd / 3rd / 4th / 5th / 6th ) year during the proposed period.

2. School will attach evidence of student’s liability insurance coverage? ( □Yes / □No )

3. School will attach evidence of student’s personal health coverage? ( □Yes / □No )

4. Assessment of academic ability: ( □Above Average / □Average / □Below Average )

5. The student has completed the required clerkships: Medicine, Pediatrics, Psychiatry, Surgery, OB/Gyne ***prior*** to this elective?

( □Yes / □No )

Other experienced clerkships if any:

6. Your evaluation form will be ( □attached / □sent later / □brought by student / □complied with Chiba Evaluation form /

□not necessary ).

※If you wish to use your university's own form, please be sure to send it to Chiba University at the time of application

7. The Evaluation should be sent by ( □Email: to or

 □EMS: to )

 Faculty Name, Title Address City State Zip Code

Signature:

**Please submit the application to:**

Student Affairs Unit for School of Medicine, Student Affairs Division,

Inohana Area Administration Department,

Chiba University

Email:igaku-ryugaku@chiba-u.jp

1-8-1 Inohana, Chuo-ku, Chiba 260-8670 Japan

Email: inohana-plan@chiba-u.jp

Date:

(print)

 Name School seal or stamp

 Title