



Chiba University School of Medicine

**VISITING MEDICAL STUDENT APPLICATION FOR ELECTIVE COURSES IN CHIBA**

**PART I. TO BE COMPLETED BY THE VISITING STUDENT**

1. NAME (print legibly): \_\_\_\_\_  
Last (Family) Name First

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Year Month Date

2. Permanent Address: \_\_\_\_\_  
House Number Street Apartment/Suite #  
\_\_\_\_\_ City State/Province Zip/Postal Code Country

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

E-Mail: \_\_\_\_\_@\_\_\_\_\_

Skype ID: \_\_\_\_\_



3. CONTACT PERSON IN CASE OF EMERGENCY \_\_\_\_\_

4. OBJECTIVE (Research / Observation / Lecture / Clinical Clerkship Elective)

5. INTENDED PERIOD  
Begin Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weeks \_\_\_\_ w (and/or) \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_ w

6. PREFERENCE OF DEPARTMENTS(3 choices)

1st \_\_\_\_\_ 2nd \_\_\_\_\_ 3rd \_\_\_\_\_

(Japanese Ability: fluently / Beginner / Little / None )

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

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**PART II. TO BE COMPLETED BY THE DEAN OR DESIGNEE OF VISITING STUDENT'S MEDICAL SCHOOL**

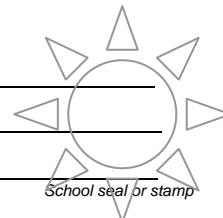
- The student will be registered in his/her ( 1st 2nd 3rd 4th 5th 6th ) year during the proposed elective.
- School will attach evidence of student's liability insurance coverage? (Yes / No )
- School will attach evidence of student's personal health coverage? (Yes / No )
- Assessment of academic ability: (Above Average / Average / Below Average )  
Assessment of clinical ability: (Above Average / Average / Below Average )
- have completed the required clerkships: Medicine, Pediatrics, Psychiatry, Surgery, OB/Gyne **prior** to this elective? (Yes / No)  
Other experienced clerkships if any: \_\_\_\_\_
- Your evaluation form will be (Attached / Sent later / Brought by students / Complied with Chiba Evaluation form / Not necessary)
- Return Evaluation to be sent to (by mail @ \_\_\_\_\_ or \_\_\_\_\_  
by EMS to \_\_\_\_\_  
Faculty Name & Title Address City State Zip Code

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

(print) \_\_\_\_\_  
First and Last Name

\_\_\_\_\_ Title



Please return complete application to:  
International Affairs & Public Relations  
School of Medicine Chiba University  
1-8-1 Inohana, Chuo-ku Chiba 260-8670 Japan