

University of Arkansas College of Medicine
Visiting Student Application

Must be accompanied by other required documentation (see our website at http://www.uams.edu/com/students/visiting_students.asp)

SECTION I: TO BE COMPLETED BY THE STUDENT AND DEAN'S OFFICE OF STUDENT'S SCHOOL.

Name of Applicant _____ Date: _____

Address: _____

Student Phone: _____ Email Address: _____

Parent Medical School: _____

Parent Medical School Address: _____

Student Affairs Contact Person: _____

School Phone: _____ Fax: _____ Email: _____

Statement of the Visiting Medical Student:

I am aware of the following:

1. Evaluation of my performance while studying at the University of Arkansas College of Medicine will be based on the same criteria as those used to judge matriculated Arkansas students. An evaluation will be submitted to my parent medical school.
2. I will not be covered by University of Arkansas health insurance and must provide proof of other coverage.
3. If my own school does not provide Professional Liability Insurance (malpractice) for me while on this rotation, I must obtain coverage from UAMS (at no charge to me) by completing an application for same on the first day of my visiting rotation.
4. I am requested to call as soon as possible if my situation changes and I am unable to take the indicated elective course. I am aware that if I fail to notify the University of Arkansas Academic Affairs office that I will not be attending the course, my dean's office will be notified.

Signature of Visiting Student

Title of Elective Course You Wish To Take: *** You may list additional choices for courses or course dates on a separate sheet of paper.

1st choice: _____ Block (or dates): _____ 2nd choice: _____ Block (or dates): _____

Statement of Dean from Parent Medical School:

I certify that the above named student is in good standing at the _____ School of Medicine and has permission to study for credit at the University of Arkansas College of Medicine for the period listed above.

Signature of Dean or Dean's Representative of
the Parent Medical School

Upon completion of this form to this point, the potential visiting student should return it to:

Richard P. Wheeler, M.D.
Executive Associate Dean for Academic Affairs
University of Arkansas College of Medicine
4301 W. Markham, Slot 603
Little Rock, AR 72205

SECTION II: TO BE COMPLETED BY THE UNIVERSITY OF ARKANSAS.

Statement of University of Arkansas College of Medicine Sponsor:

APPROVAL:

This student has been accepted as a visiting student. The _____ department has been notified that this student will be rotating for the month of _____ during block _____.

He/She should report to: _____

Place: _____

Date/Time: _____

Office of Academic Affairs Signature