Application for Clerkship Instruction (For Non SKMC Students)

Sidney Kimmel Medical College, Philadelphia, PA

I.

FROM: _____
Student Name *Medical School* Class

TO: _____
Department Chair/Preceptor *Department*

I hereby request to be enrolled in _____
Course# and Name

Starting _____ and ending _____.
mm/dd/yy mm/dd/yy

My address is : _____

_____

I understand that I can only take a maximum of 8weeks of clerkships as a non SKMC Student.

- ☐ I have not taken any previous clerkship at Sidney Kimmel Medical College.
- ☐ I have taken _____ weeks of clerkships in _____
  #of weeks Department

_____
Email address: Signature Date

II. Medical School Certification (from Students' Parent School):

- ☐ The above named student is in good standing at this medical school.
- ☐ This student: ☐**WILL** ☐ **WILL NOT** -pay tuition at this school during the period indicated.

The malpractice/liability insurance at this school ☐**Does** ☐ **Does NOT** –cover the student away from your school.
Personal health coverage ☐**IS** ☐**ISNOT** –in effect away from this school.
The student is authorized to take this clinical instruction ☐**YES** ☐**NO**
At the conclusion of this program a report ☐**WILL** ☐ **WILL NOT** be required.

_____
Name of Dean's Representative Signature Of Dean Or Dean Representative Title if Dean's Representative

III. Sidney Kimmel Medical College Registrar Approval

Application: ☐ Approved ☐ Denied, Reason _____

☐ Previous Enrollment – Number of weeks _____

_____
Registrar/ Representative Signature Date

IV. Sidney Kimmel Medical College Department Approval

This application for clerkship instruction ☐ IS ☐ IS NOT approved for the period:

_____ to _____
Starting date Ending date

You are expected to report to _____
Name of person

Located _____
Street Address, Building, Room#

At _____

_____ _____
Department Chairmen/ Representative Signature Date