



UNIVERSITY OF PUERTO RICO
MEDICAL SCIENCES CAMPUS
SCHOOL OF MEDICINE



APPLICATION FOR **REQUIRED/SELECTIVE***
CLINICAL COURSE AT USA ACCREDITED
SCHOOL OF MEDICINE, 2011 – 2012

DATE : _____

STUDENT NAME : _____

STUDENT NUMBER : _____

ADDRESS : _____

TELEPHONE : _____ E-MAIL : _____

CEL. PHONE : _____

INSTITUTION APPLIED : _____

DATES REQUESTED : FROM: _____ TO: _____

TITLE OF ELECTIVE COURSE _____

DEPARTMENT CONCERNED _____
(Please furnish copy of the description of the Elective Requested)

A COURSE APPROVAL:

Head of Department
School of Medicine
University of Puerto Rico

Approval of Curriculum Director

*This is a requirement for students in good standing who wish to take a clinical experience outside the clinical facilities of the UPR, School of Medicine. Extended coverage for Liability Insurance must be requested to the Office of the Dean for Students Affairs (Room 873) by completing the appropriate form.



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