

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY
ROBERT WOOD JOHNSON MEDICAL SCHOOL AT CAMDEN
401 HADDON AVENUE, ROOM #154
CAMDEN, NJ 08103
PHONE #: 856-757-7859

PLEASE ATTACH COPIES OF:

- Personal Health Insurance Confirm.
- Medical Liability Insurance Confirm.
- Immunization Records Confirmation
- Criminal Background Check
- Signed Essential Functions

VISITING STUDENT APPLICATION

Robert Wood Johnson Medical School accepts electives applications from students enrolled full-time in LCME accredited medical schools.

I. STUDENT INFORMATION AND ELECTIVE REQUEST (To be completed by student)

NAME: _____ SOCIAL SECURITY# _____

ADDRESS: _____ E-MAIL ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE NUMBER: _____

List elective you are interested in taking, with three sets of possible dates. Additional requests should be submitted on a separate form.

COURSE TITLE COURSE # # OF WEEKS BEGINNING/END DATES

1. _____
2. _____
3. _____

At the time of the requested elective, I will have completed the following Third Year clinical clerkships: (list number of weeks next to clerkship)

FAMILY MEDICINE ___ MEDICINE ___ OB/GYN ___ PEDIATRICS ___ PSYCHIATRY ___ SURGERY ___

Student Signature

Date

II. CERTIFICATION OF ELIGIBILITY (To be completed by Dean of Students or comparable official of Home School)

The medical student named above is in good standing in the Class of _____. The student **will** pay tuition at our school during the period indicated. Malpractice insurance **does** cover the student away from our school. Personal health coverage **is** in effect away from our school. The student is approved to take this elective **for credit**. At the conclusion of the elective an evaluation report **will (copy attached) /will not be required**.

Signature Name Title Date

Home Medical School and Address: _____

III. DEPARTMENTAL APPROVAL (To be completed by RWJMS-C course director)

APPROVED ___ DISAPPROVED ___

The student will report to: Name: _____ Date: _____

Place: _____ Time: _____

Course Director's Signature: _____ Date: _____

IV: FEES CHARGED: *PARKING OPTIONAL - \$21.40 PER CALENDAR MONTH*

**UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY
ROBERT WOOD JOHNSON MEDICAL SCHOOL AT CAMDEN**

VISITING STUDENTS IMMUNE STATUS

NAME: _____ **SOCIAL SECURITY #** _____ **DOB:** _____

Health Service Use Only

(Please Check)

- | | | | | |
|----|---|--------------------------------|-------------|-----------|
| 1. | Complete History and Physical
(Within 12 months) | Date: _____ | NEED | OK |
| | | | _____ | _____ |
| 2. | Tuberculin Testing (Within 12 months) | | _____ | _____ |
| | PPD Date: _____ | Result: _____ mm. | | |
| | If Positive PPD: Chest X-Ray | Yes ___ No ___ Date: _____ | | |
| | | Result: Normal _____ | | |
| | | Abnormal _____ (attach report) | | |
| 3. | Measles, Mumps, Rubella | | | |
| | 1. Birthdate Prior to 1957 | _____ (Exempt) | _____ | _____ |
| | Or | | | |
| | 2. Two Doses of Vaccine | Dates: _____ | | |
| | <i>(After the first birthday, no less than one month apart; at least one dose in or after 1980)</i> | | | |
| | Or | | | |
| | 3. Serologic Immunity | Date: _____ | | |
| 4. | Varicella | | | |
| | 1. Two Doses of Vaccine | Date: _____ | _____ | _____ |
| | Or | | | |
| | 2. Serologic Immunity | Date: _____ | | |
| 5. | Hepatitis B | | | |
| | 1. Three Does of Vaccine | Date: _____ | _____ | _____ |
| | Or | | | |
| | 2. Serologic Immunity | Date: _____ | | |
| 6. | Influenza | Date: _____ | _____ | _____ |
| 7. | Tetanus/Diphtheria (Td) | Last Booster - Date: _____ | _____ | _____ |

The student has satisfied all immunization requirements cited above.

_____ <i>Signature (Health Services or Dean)</i>	_____ <i>Name</i>	_____ <i>Title</i>	_____ <i>Date</i>
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The student has not satisfied the _____ immunization.

_____ <i>Signature(Health Services or Dean)</i>	_____ <i>Name</i>	_____ <i>Title</i>	_____ <i>Date</i>
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