

Temple University School of Medicine
Clinical Campus at The Western Pennsylvania Hospital

Application for LCME-/AOA-Approved Schools – Student Electives

Please complete the entire form and return it to the Office of the Associate Dean, The Western Pennsylvania Hospital, 4800 Friendship Avenue, Room 2318, North Tower, Pittsburgh, PA 15224.

An individual application must be completed for each requested elective when requesting more than one.

Name: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ E-mail Address: _____

Medical School: _____

Requested Elective: _____

Dates: From: _____ to _____

Alternate Dates: From: _____ to _____

Student Must Provide the Following:

Yes No

Letter of Good Standing from Medical School

Immunization Documentation, including titers and PPD (attached)

Proof of Personal Health Insurance

Proof of Malpractice/Liability Insurance

An evaluation will be required (copy of School's Evaluation form must be provided)

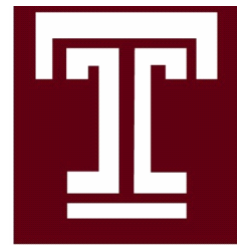
Housing Needed

Parking Needed

Signature: _____ Title: _____

Date: _____

**All requested information must be received four (4) weeks
prior to the start of the requested rotation.**



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Documented Proof of Required Immunizations

Student Name: _____

Medical School: _____

_____ Diphtheria/Tetanus (booster within ten years) _____/_____
 Month/Year

_____ Oral Polio Vaccine (OPV or IPV) _____/_____
 Month/Year

_____ Rubella live virus vaccination or positive titer _____/_____
 Month/Year

_____ Rubeola, disease history or live virus vaccination
 after January 1, 1969 or positive titer _____/_____
 Month/Year

_____ Mumps, disease history or live virus vaccination or positive titer _____/_____
 Month/Year

_____ Hepatitis B vaccination series completed _____/_____
 Month/Year

_____ Tuberculin status documented within the last six months
 (if positive results must provide copy of radiology report
 and doctor's letter) _____/_____
 Month/Year
 Results: ☐ Negative ☐ Positive

_____ Chicken Pox disease history or positive titer or proof of immunization _____/_____
 Month/Year

Healthcare Provider:

Name (please print): _____

Signature: _____

Date: _____

Address: _____

Telephone: () _____