GENERAL GUIDELINES FOR VISITING STUDENTS IN ELECTIVE COURSES
Students in good academic standing from Liaison Committee on Medical Education (LCME) accredited medical schools may be considered for any elective listed at the University of Puerto Rico School of Medicine manual. Students from non-accredited Schools of Medicine by the LCME may be considered if complying with the same requisites and subject to space, for up to three months.

**ELEGIBILITY:**

To be eligible the student must:

1. Have completed the pre-requisites of the course selected.

   For fourth year courses, have the following third year course requirements:

   - Internal Medicine: 10 weeks
   - Pediatrics: 9 weeks
   - OB/Gyn: 6 weeks
   - Family Medicine: 4 weeks
   - Surgery: 9 weeks
   - Radiology: 2 weeks
   - Psychiatry: 6 weeks

   “See elective for specific requirements”

2. Complete the Visiting Student Application Form and Visiting Student Health Record Form in all parts and submit to the Curriculum Office at least two months prior to the requested date for the Elective Course(s).

   Application should be sent to:
   
   University of Puerto Rico, Medical Sciences Campus  
   School of Medicine, Curriculum Office, 8th floor, #A-868  
   PO Box 365067  
   San Juan, PR 00936-5067

3. Have a written authorization from the Dean of Clinical Affairs or authorized delegate of the parent School of Medicine expressing the approval of the student’s request.

4. Be covered by the parent institution with the Professional Liability Insurance. If not available, the applicant must show evidence of personal Professional Liability Insurance coverage.

6. Submit a transcript of the medical courses approved with a **minimum of 2.50 point average** or its equivalent (Class Ranking). If the school has an honor system our translation will be as follow:

   - Outstanding = 4  
   - Satisfactory = 3  
   - Unsatisfactory = 0  

   OR

   - Above Average = 3.5  
   - Average = 3  
   - Below Average = 2.5  
   - Unsatisfactory = 0
7. The student **must be fully bilingual: Spanish and English.** If the elective requested entails direct contact with patients, students must be able to **speak a fluent conversational Spanish,** as our main population is Spanish speaking. Medical records at the hospital are written in English.

8. The student will be notified regarding the status of the application after completion of the local senior students’ enrollment period on July of each calendar year.

9. **Student should first report to the UPR School of Medicine, Curriculum Office A-868 (8th floor at the Medical Sciences Campus Building), in order to start the registration process.**

10. **Visiting students can register courses which do not overpass the maximum of eight weeks duration permitted in one academic year.** Ex.

   a. one four weeks duration course
   b. one eight weeks duration course
   c. two four weeks duration courses
   d. one research elective course
   e. one research and one elective course

11. **Register as special student and pay the corresponding enrollment fee ($600.00 per course). (This fee is non-refundable if student drops a course)** That would be:

   a. one four weeks duration course = $600.00
   b. one eight weeks duration course = $1,200.00
   c. two four weeks duration courses = $1,200.00
   d. one research elective course = $600.00
   e. one research and one elective course = $1,200.00

   Exempt: Visiting Students from Schools of Medicine with which our SOM has an institutional exchange program agreement stipulating the registration fee exemption.

12. **Withdrawals must be done within one month in advance.**

13. **Copy of the official government state student VISA for the period of the elective(s).** **(For Non-USA Citizens)**

14. **Student must report to the Medical Faculty Office in the hospital assigned, for hospital identification.**

15. **Student must wear the student Identification Card from his/her School at all times during the elective.**

16. **Student will receive academic credit from their own medical school for the elective course taken at the UPR School of Medicine.** Evaluation form will be sent to the parent institution when received at the Curriculum Office, University of Puerto Rico, School of Medicine.

17. **Foreign (not USA citizens) students must follow the following procedures:**

   a) As soon as the student receives the acceptance letter, he/she must get in touch with the RCM DSO (Designated School Official) for foreign students program: Mr. Reinaldo Pomales, 1-787-758-2525 Ext. 5328, 787-756-7944 Fx or reinaldo.pomales@upr.edu; and send him the letter of acceptance.

   b) Complete the Form I-20 (Eligibility Certificate) that the DSO will send to you so you can apply for the F-1 Visa classification at the US Consulate in your country. **US State Department’s F-1 is**
the student classification visa for non-in-migrant. **Students with B1/B2 visa cannot matriculate until they have changed their visa classification to F-1.**

c) **F-1 visa** classified students cannot be admitted 30 days before classes begin or before the beginning date written in the I-20 Form. Students must matriculate no later than the last day for courses changes.

d) Required documents for the F-1 Visa:
   - Admission certificate
   - Economic solvency evidence in **original documents**: Affidavit from parents or guardian

(*The University of Puerto Rico reserves the right to accept any exchange student in accordance to local rules and regulations*)

**OFFICE CONTACTS:**

For any additional information, student should contact:

**Delia Herrera, MSW, LSW**  
**Curriculum Office Coordinator**  
**University of Puerto Rico, School of Medicine**  
**Telephone**: (787) 758-2525, Ext. 2219  
**Fax Number**: (787) 758-4029  
**Mail to**: delia.herrera@upr.edu

**WEBSITE ADDRESS:**

Website for Manual and Application Form:  

http://www.md.rcm.upr.edu/curriculum

**WEBSITE FOR REGISTRARS OFFICE AND SERVICES:**

http://www.rcm.upr.edu
VISITING STUDENT APPLICATION FORM
UNIVERSITY OF PUERTO RICO
MEDICAL SCIENCES CAMPUS
SCHOOL OF MEDICINE

VISITING STUDENT APPLICATION FORM

DATE: ____________________________

I PERSONAL INFORMATION

NAME OF APPLICANT:
______________________________________________________________________________________

ADDRESS:
______________________________________________________________________________________  
______________________________________________________________________________________

______________________________________________________________________________________

TELEPHONE: ___________________________ SOCIAL SECURITY#: _________________

E-MAIL ADDRESS: ___________________________

MALE: _________ FEMALE _________ UPR STUDENT NUMBER: __________________

II ELECTIVE (S) COURSE (S) REQUESTED

(1) COURSE # AND TITLE: __________________________________________________

DATES: __________________________________________________

HOSPITAL: __________________________________________________

(2) COURSE # AND TITLE: __________________________________________________

DATES: __________________________________________________

HOSPITAL: __________________________________________________

___________________________________

Student Signature

III APPROVAL: FROM DEAN OF STUDENT OR COMPARABLE OFFICIAL WHERE STUDENT IS ENROLLED.

The medical student named above is in good standing at this institution and has approval to take the above elective (s). Liability insurance (does) (does not) cover the student away from our school while taking this course at your institution. He/she (is) (is not) covered by student health insurance. At the conclusion of the course or clerkship, an evaluation report (is) (is not) required.

Authorizing Officer Name: ___________________________ Date: ______________________________

Signature: ___________________________ School: ___________________________

Title: ___________________________ Address: ___________________________

E-Mail Address: ___________________________

IV DATE RECEIVED AT CURRICULUM OFFICE: _____________

V
## Visiting Student Health Record Form

**Name** __________________________________________________________
**Last**                  **First**
**Address** _______________________________________________________________________________________
**Street** ______________________________________________**Medical Insurance Valid in PR** ____________________
**City**                                         **Zip Code**

**Program** ________________ **Social Security #____-____-_____**
**Phone** ________________________

**Persons to be contact in case of emergency** _____________________________________________________
**Phone** _________________________________ **Cell Phone** _________________________________________

**Health condition(s) that may require attention during your stay** _____________/______________/__________

### VACCINES

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date:</th>
<th>MONTH / DAY / YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tetanus-Diphtheria Booster</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receive within past 10 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measies/Mumps/Rubella (MMR)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two doses required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or if given separately:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles (2 doses) Live virus only or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Antibody Titer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps or Positive Antibody Titer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Vaccine within the past three years</td>
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<td></td>
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<tr>
<td><strong>Hepatitis B</strong></td>
<td></td>
<td></td>
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<tr>
<td>or Positive Antibody Titer (anti-HBS)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Tuberculin Test (Mantoux)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within the past 12 months Date</td>
<td></td>
<td></td>
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<tr>
<td><strong>Chest X-Ray</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required if TB Positive within the past year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had BCG Vaccine: _____Yes _____No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INH Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____Yes _____No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Varicella (Chicken pox)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had Disease: _____Yes _____No _____Unknow</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccine Date</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Polio Date of last booster</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Drug Allergies?** ______________________________________________________________________________

**Do you need reasonable accommodation?** __________________________________________________________________

**Required:**
- Physician’s or Nurse Name Print ____________________________________  Physician’s or Nurse Signature ___________
- Physician’s Address ____________________________________________
  **License No.** _______________  **Phone Number** _____________________  **Date** _______________________

*Please, fill all blanks with your doctor and return this document to Student Medical Services, PO Box 365067 San Juan PR 00936-5067 or deliver personally to Student Medical Services, 3rd floor, Main Building of the Medical Sciences Campus. Tel (787) 758-2525 Exts. 1215 & 1216  Fax: (787) 766-0122*