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.*

I hereby certify the medical student named above

A. has being authorize to take the above elective(s)
B. is in his/her final year
C. Is in good academic standing at this institution
D. has a Liability Insurance coverage while taking this course at your institution
E. is covered by a Student Health Insurance while taking this course at your institution
F. (Will/Will not) need an Evaluation Report at the conclusion of the course or clerkship

Authorizing Officer Name : _____ *Date :* _____

Signature : _____ *School :* _____

Title : _____ *Address:* _____

E-Mail Address : _____ _____

DATE RECEIVED AT CURRICULUM OFFICE: _____

Visiting Student Health Record Form

Name _____ *Birth Date* _____/_____/_____
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	*DATE: MONTH / DAY / YEAR*
Tetanus-Diphtheria Booster *Receive within past 10 years*	_____/_____/_____
Measies/Mumps/Rubella (MMR) *Two doses required* *or if given separately:* *Measles (2 doses) Live virus only or* *Positive Antibody Titer* *Mumps or Positive Antibody Titer* *Rubella or Positive Antibody Titer* *Or Vaccination within the past three years*	*Dose 1* ____/____/____ *Dose 2* ____/____/____ *(MMR)* *Dose 1* ____/____/____ *Dose 2* ____/____/____ *(Measles) or + Titer* ____/____/____ *Result:* _____ *Dose 1* ____/____/____ *or + Titer* ____/____/____ *Result:* _____ *Dose 1* ____/____/____ *or + Titer* ____/____/____ *Result:* _____
Hepatitis B *or Positive Antibody Titer (anti-HBS)*	*Dose 1* ____/____/____ *Dose 2* ____/____/____ *Dose 3* ____/____/____ *or + Titer* ____/____/____ *Result:* _____
Tuberculine Test (Mantoux) *Within the past 12 months Date* _____ *Chest X-Ray* *Required if TB Positive within the past year* *Had BCG Vaccine:* _____*Yes* _____*No* *INH Treatment : _____Yes _____No*	*Circle Result: Negative Positive Date* ____/____/____ *X Ray Result: Negative Positive Date* ____/____/____ *Length of Treatment:* *From:* ____/____/____ *to* ____/____/____
Varicella (Chicken pox) *Vaccine: Date:* _____/_____/_____	*Had Disease:* ____ *Yes* ____ *No* ____ *Unknow* *Dose 1* ____/____/____ *Dose 2* ____/____/____
Polio Date of last booster	*Last Dose* ____/____/____

Drug Allergies? _____
Do you need reasonable accommodation? _____

Required:

Physician's or Nurse Name Print _____ *Physician's or Nurse Signature* _____
Physician's Address _____
Lic. 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*