

**WEILL CORNELL MEDICAL COLLEGE
INTERNATIONAL ELECTIVE APPLICATION FORM**

Complete and return application to:
Ms. Dianne E. Young
Office of Global Health Education
Weill Medical College of Cornell University
425 East 61st Street, Suite DV-321
New York, NY 10065

A: PERSONAL INFORMATION.

To be completed by student. Please print or type:

NAME		
Last	First	Middle
Male []	Female []	
Date of Birth [M/D/Y]		
Citizenship		

Mailing Address

Street		
Apt #		
City		
State	Zip	
Country		
Internet (e-mail) address		
Telephone Number		
Medical School Attending	Country of Medical School	Expected Degree and Date

Emergency Contact

Name	Telephone
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B: ELECTIVE CHOICES AND DATES

*(Use website to find the elective number that correlates with your choices) You must specify 3 choices!!
Sub-Internships not available*

Module	Dates	Course # of 1 st Choice	Course# of 2 nd Choice	Course# of 3 rd Choice

I have read and understand all the application materials. I attest that the information given in this application is accurate and true.

Student's Signature: _____ Date: _____

- Attach: Dean/Registrar Verification Form Transcript
 Dean's letter Statement of Intent
 Health Statement Form Curriculum Vitae
 Health Insurance policy Application Fee \$100US Malpractice insurance policy (if available)

