

**Weill Medical College of Cornell University  
International Elective Program**

**DEAN OR REGISTRAR VERIFICATION FORM**

Please read the attached description of our program and the student's request.

Name of Student: \_\_\_\_\_

The above student has applied for elective rotations at the Weill Medical College of Cornell University during the dates of : \_\_\_\_\_ to \_\_\_\_\_  
Month /day/year                      Month /day/year

Requested information should be filled in and /or appropriate responses checked below.

	YES	NO
Is this student in good academic standing?	<input type="checkbox"/>	<input type="checkbox"/>
Will student be covered by personal health insurance while in US?	<input type="checkbox"/>	<input type="checkbox"/>
Will student be covered by malpractice or indemnity insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Is student fluent in English?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel student is qualified for electives he/she has selected?	<input type="checkbox"/>	<input type="checkbox"/>

**Dean or Registrar, please complete.**

Authorized by (**Print name**) : \_\_\_\_\_

Position at School:     Dean             Registrar     Other

School \_\_\_\_\_

Address \_\_\_\_\_

Country \_\_\_\_\_

Telephone \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please attach your letter of recommendation.**