山東大學醫學院
SHANDONG UNIVERSITY SCHOOL OF MEDICINE
Jinan Shandong
P.R.China 250012
TEL: 86-531-8838-2725
FAX:86-531-8838-2502
http://www.medicine.sdu.edu.cn/
E-mail: xiajing@sdu.edu.cn

Clinical Electives Application for International Medical Students

SECTION I: **TO BE COMPLETED BY STUDENT.**

Personal Details

Student's Name (Last First Middle) _____

Mailing Address (Street Address City/State/Country Zip Code)

_____

Date of Birth (MM/DD/YY) _____Nationality at Birth _____

Passport Number _____Gender: ( ) Male ( ) Female

Phone # _____

FAX # _____

E-Mail _____

Emergency Contact Name & Phone # _____

Language Details

How would you describe your Chinese skill (none/little/conversational/proficient)___

Have you completed a medical Chinese class? _____

Medical Education Details

Current Medical School _____

Degree (MD, MD/PhD) _____

Specialty of Interest _____

Current Year of Training_____

Which courses have you completed in biology or medicine at home university? Could you please provide your cumulative GPA of the courses you have completed?

_____

_____

Have you completed all the required preclinical courses from MS1-MS2? _____

What would you like to gain from your rotation at Shandong University School of Medicine? _____

山東大學醫學院
SHANDONG UNIVERSITY SCHOOL OF MEDICINE
Jinan Shandong
P.R.China 250012
TEL: 86-531-8838-2725
FAX:86-531-8838-2502
http://www.medicine.sdu.edu.cn/
E-mail: xiajing@sdu.edu.cn

Please indicate your choice for training department and duration of stay clearly.

Number them preferentially. (1=first choice, 2=second choice, 3=third choice…)

Departments		**Choices**	**Days**
1) Internal Medicine	Respiratory		
	Cardiology		
	Gastroenterology		
	Hematology		
	Nephrology		
	Endocrinology		
2) Surgery	Hepatobiliary		
	Gastroenterology		
	Orthopedic		
	Urinary		
	Cardiac		
	Thoracic		
3) Gynecology			
4) Obstetrics			
5) Pediatrics			
6) Neurology (or Neurosurgery)			
7) Infectious Disease			
8) Ophthalmology			
9) Dermatology and Venereology			
10) Anesthetics			
11) Family Medicine			

Clinical rotation period requested

From (MM/DD/YY) _____to (MM/DD/YY) _____

Please state your previous clinical rotation, if any.

_____

_____

_____

==========

山東大學醫學院
SHANDONG UNIVERSITY SCHOOL OF MEDICINE
Jinan Shandong
P.R.China 250012
TEL: 86-531-8838-2725
FAX:86-531-8838-2502
http://www.medicine.sdu.edu.cn/
E-mail: xiajing@sdu.edu.cn

SECTION II: **TO BE COMPLETED BY DEAN OR AUTHORIZED OFFICIAL OF STUDENT'S MEDICAL SCHOOL.**

- The applicant is a _____ year medical student in good standing at this institution and is authorized to take this elective. (Please fill in the student grade.)
- The student has completed all Basic Science courses. (Yes □ No □)
- The student is covered by health insurance. (Yes □ No □)

As the Dean or authorized official of this student's home institution, I certify the above information to be correct and accurate.

_____

NAME OF AUTHORIZED SCHOOL OFFICIAL (type or print)

_____

DATE

_____

SIGNATURE

_____

TITLE

NAME OF SCHOOL_____

ADDRESS_____

PHONE # _____

FAX # _____

==========

山東大學醫學院
SHANDONG UNIVERSITY SCHOOL OF MEDICINE
Jinan Shandong
P.R.China 250012
TEL: 86-531-8838-2725
FAX:86-531-8838-2502
http://www.medicine.sdu.edu.cn/
E-mail: xiajing@sdu.edu.cn

COMPLETE AND RETURN APPLICATION TO:

Foreign Affairs Office,
2nd Floor, Teaching Building 8,
No. 44 Wen Hua Xi Road (Shandong University, Baotuquan Campus),
Lixia District, Jinan, Shandong
Postcode: 250012