LOYOLA UNIVERSITY CHICAGO STRITCH SCHOOL OF MEDICINE

Return to Office of Registration and Records

2160 South First Avenue, Room220, Bldg.120, Maywood, IL 60153

Application for Visiting Student - Shadowing Experience

I. TO BE COMPLETED BY THE STUDENT:

Name: ______________________ Email: ______________________

AAMC ID: ______________________ Phone: ______________________

Address: ____

STREET CITY/STATE/ZIP

*Dates of Experience: From: ______________________ To: ______________________

Student is required to supply proof of current immunizations on the immunization form, which must be returned with the completed application. Visiting students will not be allowed to begin any academic experiences at Loyola-Stritch unless this certification is completed at least two weeks before the first experience begins. *The student will not be able to visit for more than the equivalent of FOUR WEEKS.

II. TO BE COMPLETED BY THE DEAN OF THE STUDENT'S MEDICAL SCHOOL:

The student named above is enrolled in good standing at this institution. At the time of the requested shadowing experience, he/she will be in the ❑M1 ❑M2 ❑M3 ❑M4 year of his/her medical school program. The student ❑will ❑will not pay tuition at our institution during the period indicated. The student ❑has ❑has not completed training in the universal precautions for the handling of body fluids and sharp instruments, TB control measures, and HIPAA compliance within the past year. Malpractice insurance at a rate of at least $1 million/$3 million ❑does ❑does not cover the student while away from our school. The student ❑will ❑will not have hospitalization insurance in effect during this period.

SIGNATURE OF SCHOOL OFFICIAL DATE

NAME OF SCHOOL OFFICIAL TITLE

NAME OF MEDICAL SCHOOL TELEPHONE NUMBER

ADDRESS CITY/STATE/ZIP

III. TO BE COMPLETED BY THE DEPARTMENT WHERE SHADOWING EXPERIENCE WILL OCCUR AT LOYOLA-STRITCH: The application of the above named student ❑ is ❑ is not approved.

This shadowing experience does not equate to an elective course and the student will not be expected or allowed to perform the same procedures as those exclusive to 3rd or 4th year medical students.

*Period: __________ Dates: __________ to __________ __________ # Days ______________________ NAME OF SHADOWING SUPERVISOR

Report to: ______________________ NAME ______________________ PLACE ______________________ DATE/TIME

Signature: ____

SHADOWING EXPERIENCE SUPERVISOR DATE

IV. TO BE COMPLETED BY THE OF LOYOLA-STRITCH OSA DEAN OR *REGISTRAR*:

Your shadowing request has been approved as specified in Section III above. Please note, you will not be registered as a Loyola student, nor will you charged tuition as a Loyola student. Should your plans change, cancellation notification for this experience must be made to the Office of Registration & Records at Loyola as well as with the department listed above.

Signature ____

LOYOLA-STRITCH OSA DEAN OR REGISTRAR DATE

When all sections are completed, student and shadowing supervisor will be notified via email.

***The student will not be able to visit for more than the equivalent of FOUR WEEKS.**