WEILL CORNELL MEDICAL COLLEGE
INTERNATIONAL ELECTIVE APPLICATION FORM

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

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

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 1st Choice**	**Course# of 2nd Choice**	**Course# of 3rd 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)