Keio University School of Medicine
International Student Clinical Elective Program

As of January, 2024

Please attach your photo.

Application Form

Personal Information

Last Name: ______________ First Name: ______________

Email Address: ______________ Telephone Number: ______________

Primary Mailing Address: ______________

____

Date of Birth (YYYY/MM/DD): ______________ Gender: ______________

Nationality: ______________ Year (must be the final year): _ year / _ year (e.g., 6th /6th)

Emergency Contact Information

Last Name: ______________ First Name: ______________

Email Address: ______________ Telephone Number: ______________

Relationship to Student: ______________

Home Institution

School Name: ______________ Country: ______________

Address: ______________

International Coordinator or Contact Name: ______________

Email: ______________ Telephone Number: ______________

Program Request

Please list the departments in order of your preference (Be sure to list 6)

Clinical Department List & Schedule

Clinical Department	
1	
2	
3	
4	
5	
6	

Please choose the block and fill out the period based on the Clinical Department List & Schedule in order of your preference with a minimum of 1 to a maximum of 4.

Elective Period	
Ex.	Block 1 (YYYY/MM/DD – YYYY/MM/DD)
1	
2	
3	

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4	

If none of the preformed block schedule fits, please specify the preferred dates.

Housing Request

Daikyocho Guest Rooms

☐Yes ☐No

Note: It may not always be what you request since there are only six private rooms available in the residence. In that case, students may need to book accommodation by themselves

Dean or Department Chair’s Endorsement

For completion by the Dean or Department chair of the applicant’s home Medical School or Department

I hereby confirm that the student meets all of the following criteria.

☐ 1.The above-mentioned student is in good standing at our institution.

☐ 2.The student is enrolled in their final or penultimate year of medical program.

☐ 3.The student will have completed basic bedside training in all core clinical subjects before the start of the program.

☐ 4.The student is covered by liability insurance. If not, I guarantee to make the student obtain liability insurance by their departure. (See document “Assumption of Risk and Medical Information Protection Agreement ”)

☐ 5.The student is covered by personal health insurance (If not, student must arrange by their own)

Signature of ***Dean or Department Chair*** *Date*

Print Name

Approval of Studies

To be completed by international coordinator at home institution.

I hereby agree the student to participate in Keio International Student Clinical Elective Program.

Signature *Date*

Name *Position*

Official Seal