Keio University School of Medicine
International Student Clinical Elective Program
As of December 2024

Please attach your photo.

# Student Profile

| | |
|---|---|
| Name (First) | |
| Name (Middle) | |
| NAME (LAST) | |
| Email | |
| Telephone No. | |
| Gender | |
| Year (must be the final year) (e.g., 6th /6th) | |
| Home Institution | |

# 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 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