Keio University

Keio University School of Medicine
International Student Clinical Elective Program
As of December 2025

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

Title

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

Title

Official Seal