### APPLICATION FORM FOR

###  ELECTIVE ATTACHMENT

### At Georgetown Public Hospital Corporation

Please note that faxed applications will not be accepted. Applications not received within three (3) months of requested start date will not be accepted.

**PERSONAL:**

SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CORRESPONDENCE ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS (If different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS (Please print clearly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NATIONALITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PASSPORT NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ELECTIVE***:

STATE THE DEPARTMENT/S IN WHICH YOU WOULD LIKE TO UNDERTAKE YOUR ATTACHMENT IN ORDER OF PREFERENCE and IF YOUR PREFERENCES ARE TO BE SPLIT ATTACHMENTS: (please complete each preference)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEEKS: \_\_\_\_\_\_\_\_\_ SPLIT: YES/NO (Please circle)

2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEEKS: \_\_\_\_\_\_\_\_\_ SPLIT: YES/NO (Please circle)

3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEEKS: \_\_\_\_\_\_\_\_\_ SPLIT: YES/NO (Please circle)

TOTAL NUMBER OF ELECTIVE WEEKS \_\_\_\_\_\_\_\_\_

STATE THE EXACT DATES WHEN YOU WILL BE AVAILABLE TO UNDERTAKE YOUR ELECTIVE:

FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GIVE ALTERNATIVE DATES, IF POSSIBLE: FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU CONTACTED ANY DEPARTMENT/S, IF SO WHO/WHERE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ACADEMIC:***

WHICH UNIVERSITY/MEDICAL SCHOOL DO YOU ATTEND? (Include Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENT YEAR OF STUDY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YEAR & MONTH OF GRADUATION : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### REGULATIONS/REQUIREMENTS

Elective students are required to pay a fee of US$200.00 by bank cheque/draft which is to be made payable to Georgetown Public Hospital Corporation. Please return your bank cheque/draft with the application form. Students who cancel may receive a refund if cancellation occurs at least one month prior to commencement. $50.00 will be retained as a non-refundable processing (administrative) fee. Students, who do not cancel and do not come, forfeit the fee.

(a) Neither the GPHC or its officials or representatives shall be liable for damages arising out of:

1. Death, bodily injury, loss of health or illness of any student, however caused;
2. Destruction or damage of property arrived by, or in the custody of, any student, however caused.

(b) The applicant hereby indemnifies the GPHC against and holds himself liable in respect of any claims made by any third person in respect of any damage.

(c) I agree to pay the Georgetown Public Hospital Corporation a fee of US $200.00.

I acknowledge and agree to the foregoing provisions.

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### HOME INSTITUTION

#### APPROVAL BY YOUR FACULTY

I confirm that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a full time clinical medical student in good standing at this University and is required to complete an elective period in a hospital as part of his/her course and his/her plans have my full approval.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL SCHOOL STAMP

ATTACH PHOTOGRAPH OF APPLICANT HERE