Office of the Registrar
College of Medicine
University of South Florida
Phone: (813) 974-4089

12901 Bruce B. Downs Blvd MDC 32
Tampa, FL 33612
Email: mcook@health.usf.edu
Fax: (813) 974-4619

EXTERNSHIP APPLICATION

PART I: TO BE COMPLETED BY THE USF STUDENT

Student Name _____ Student ID _____

Please check one: ☐ Domestic Elective ☐ International Elective

Home Phone _____ E-mail _____

Student Mailing Address _____

City _____ State _____ Zip _____

Course Name _____ Department _____

Course Dates _____ to _____ USF/COM Month # Please Select

Alternate Dates _____ to _____ USF/COM Month # Please Select

School/Facility to be visited _____

Application Mailing Address _____

City _____ State _____ Zip _____

School Phone# _____ Fax# _____ E-mail _____

Personal Health Coverage ☐ Yes ☐ No (It is the student's responsibility to obtain coverage.)

If an international elective, provide emergency medical insurance policy number _____

Student address while attending course _____

City _____ State _____ Zip _____

Student Signature _____ **Date** _____

PART II: TO BE COMPLETED BY USF/COM APPROVING OFFICIALS

USF Dept. Director Signature _____ **Date** _____

The medical student named above is in GOOD STANDING at this institution, has taken and passed all core clerkships (Primary/Special Populations, Med-Peds, Newborn/Maternal, EM/Urgent Care, Surgical Care, Neuropsychiatry), and has permission to take the above listed course FOR ELECTIVE CREDIT. The student will pay tuition at our institution during the period indicated. Malpractice Liability Insurance coverage of $100,000/$200,000 DOES cover the student while away from our school. Upon completion, an evaluation for this student IS required. Our student evaluation form is included. **Please return the completed evaluation within two weeks of completion of this course.**

USF Registrar Signature _____ **Date** _____

PART III: TO BE COMPLETED BY APPROVING OFFICIAL FOR EXTERNSHIP COURSE AND RETURNED TO USF COM REGISTRAR

This request is: ☐ **Approved** ☐ **Not Approved**

The student will report to:

Name _____ Date _____

Location _____ Time _____

The school/facility carries medical malpractice insurance **for its own students** with limits of liability in the amount of $_____

(***Or*** please include a copy of the university's malpractice certification letter. USF Health will provide coverage for USF students)

Approving Official Signature _____ **Date** _____

Title _____ Phone _____ E-mail _____

Please return to the USF College of Medicine Registrar at the address listed on the top of this form