UMDNJ School of Osteopathic Medicine

Office of the Registrar
1 Medical Center Drive, Suite 210
Stratford, New Jersey 08084

Phone: (856) 566-7055
Fax: (856) 566-6475

Request to Participate in a Non-Credit Clinical Experience

A. **Application Information** (To be completed by student. Please print clearly.)

Student Name _____ Student ID _____ Year of Graduation _____

Title of Externship or Non-Credit Clinical Experience _____ Dates of Activity (To/From) _____

Name and Address of Host Site _____ Street _____ City _____ State _____ Zip _____

Supervisor's Name _____ Supervisor's Telephone Number _____

Brief Description of Externship or Non-Credit Clinical Experience - attach additional descriptive information if available

Is the address listed above the location of the activity? If yes, indicate. If no, provide location address.

Student Signature _____ Date _____

B. **Approval** (to be completed by school)

The activity described above contributes to the fulfillment of the mission of the medical school.

Associate Dean or Designee Signature _____ Date _____

_____ Approved
_____ Denied

C. **Registrar Office Certification** (to be completed by the Office of the Registrar)

This osteopathic medical student is in good academic standing and has obtained permission to apply for the externship or non-credit clinical experience identified above. He/She will be in the _____ year of a 4-year program. He/She will be covered by UMDNJ's Program of Self-Insurance (limits of liability not less than $1 million/$3 million) and personal health insurance maintained by the student. He/she is certified as having completed HIPAA education and blood borne pathogen training.

Registrar Signature _____ Date _____

D. **Approval by Host** (to be completed by supervisor prior to experience and faxed to 856-566-6475)

_____This student has been accepted for placement into the above noted externship or non-credit clinical experience.

Supervisor Signature _____ Date _____

E. **Evaluation by Host** (to be completed by supervisor after experience)

_____This student has satisfactorily completed the above noted externship or non-credit clinical experience.

Comments:

Supervisor Signature _____ Date _____