

PHOTO

INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS
STANDING COMMITTEE ON PROFESSIONAL EXCHANGE
APPLICATION FORM



Please use typewriter or capital letters

Family name: _____
First name: _____
Nationality: _____
Passport number: _____ valid till: _____ / _____ / _____
Sex: male female Date of birth: _____ / _____ / _____
Medical School: _____
Medical student since: _____ year clinical student since: _____ year
Expected date of graduation: _____ / _____
Languages spoken:
Native language: _____ other languages: _____

Number of AF

STAMP of NEO

Mailing address of exchange student:

Street address: _____
City: _____ Postal code: _____ Country: _____
Phone: _____ Fax: _____
e-mail address: _____

Desired country:

1st choice: _____ 2nd choice: _____ 3rd choice: _____
City: 1. _____ City: 1. _____ City: 1. _____
2. _____ 2. _____ 2. _____
3. _____ 3. _____ 3. _____

Desired Department:

	Field studied	Exam passed		Field studied	Exam passed
1.			3.		
2.			4.		

MARK CLEARLY YES OR NO!

MARK CLEARLY YES OR NO!

Desired duration and period:

Duration in week: _____ within the period from: _____ to: _____
Desired type of clerkship: preclinical clerkship clinical clerkship

If possible, I would like to be placed together with: _____
I have health insurance coverage for this period: yes no

Date: _____ Signature of applicant: _____

Sponsors: