UNIVERSITI SAINS MALAYSIA
ELECTIVE FORM FOR VISITING STUDENT

Address of elective secretariat:

Chairman of Elective Program
School of Medical Science
Health of Campus
Universiti Sains Malaysia
16150 Kubang Kerian
Kelantan. MALAYSIA
Email: dinsuhaimi@usm.my

PERSONAL DATA
Name:__________________________________________

Mailing Address:

Male/Female: Date/Place of Birth:

Nationality: NRIC No. (Malaysian student only):

Latest e-mail address (compulsory item):

PASSPORT PARTICULAR:
Number:

Date of issue: Date of Expiration:
PARTICULAR OF PARENT / GUARDIAN:

Name:

Telephone: Fax:

PERMANENT ADDRESS

Street / house number:

Town: State:

Country: Postal Code:

Telephone: Fax:

CONTACT PERSON IN CASE OF EMERGENCY

Name:

Telephone: Fax:

Email address (compulsory item):

HOME UNIVERSITY

Name of University:

Year of study at present:

Degree to be awarded upon graduation:

Address:

Telephone: Fax:

Email address:
## QUALIFICATION

<table>
<thead>
<tr>
<th>School/Institution</th>
<th>Year</th>
<th>Diploma/Cert./Degree</th>
<th>Major</th>
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<tbody>
<tr>
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## LEARNING OBJECTIVES
At the end of placement, what do you want to achieve?

a.

b.

c.

## ACCOMODATION
You are responsible for your own accommodation. Should you require any assistant, please kindly contact the hostel manager via email at: [shiken_ahmad@yahoo.com](mailto:shiken_ahmad@yahoo.com) or [norashiken@usm.my](mailto:norashiken@usm.my)
WHAT TYPE OF ELECTIVE DO YOU PREFER?

Clinical /Hospital Based ( )
Lab Based ( )
Community Based ( )
Research Based ( )

Specialty in which elective is sought (please give number according to your preference if you choose to have more than 1 choice):

<table>
<thead>
<tr>
<th>Specialty</th>
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<tbody>
<tr>
<td>Internal Medicine</td>
<td>Cardiac surgery</td>
</tr>
<tr>
<td>Pediatric</td>
<td>Neurosurgery</td>
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<tr>
<td>Psychiatric</td>
<td>Reconstructive surgery</td>
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<tr>
<td>General Surgery</td>
<td>Pathology</td>
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<tr>
<td>Orthopedic</td>
<td>Immunology</td>
</tr>
<tr>
<td>Obstetric &amp; Gynecology</td>
<td>Microbiology &amp; Parasitology</td>
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<tr>
<td>Ophthalmology</td>
<td>Clinical hematology</td>
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<tr>
<td>Otolaryngology</td>
<td>Community Medicine</td>
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<tr>
<td>Human Genome</td>
<td>Family Medicine</td>
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<tr>
<td>Emergency Medicine</td>
<td>Radiology</td>
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</table>

(Minimum weeks of each placement is 2 weeks and maximum number of posting allowed is ONLY three)

- For those who want to do research elective, they need to identify and confirm the supervisor from USM beforehand. They can search the list of department at our website www.medic.usm.my. The list of lecturer is included. The research title needs to be ethically approved by the home university and USM will not give any financial support. USM will not be responsible for any rejection and progression of the project.

Proposed date of Elective:

From: ___________________________ to ___________________________

I certify that the information I have provided on this application form is complete and accurate to the best of my knowledge. I understand that misrepresentation of information on this application form will be deemed as sufficient ground by USM to withdraw its offer of admission or cancel my registration.

Date: ___________________________  Applicant’s Signature: ___________________________
Recommendation by the Dean/Supervisor of the applicant’s Medical/Health Sciences Faculty (or attaches any recommendation letter):

________________________________________________________________________

________________________________________________________________________

Date: ___________________ Signature: ___________________

Official Stamp: ___________________ Name: ___________________

Recommendation of the Elective Chairman, School of Medical Sciences, USM

Recommended

Not recommended

Reason:

Date: ___________________ Signature: ___________________

Comment of Dean of the School of Medical Sciences, USM

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Application approved / not approved

Date: ___________________ Signature: ___________________

Dean of the School of Medical Sciences

* Delete whichever is not applicable