

Email _____

Fax _____ Phone _____

**University of Kentucky College of Medicine
Application for Visiting Student Elective**

Student Name _____
Last name First Name Middle IN.

TO BE COMPLETED BY THE UNIVERSITY OF KENTUCKY COLLEGE OF MEDICINE

Approved _____ Denied _____

Approved/Denied by: _____
(Signature)

Approved/Denied by; _____ Date _____
(Print)

If approved, please complete the following information:

Course# _____ Course Title _____

Dates of attendance _____

Departmental Contact _____

Phone _____ Email _____

Please return to: Renee Seidel,
University of Kentucky College of Medicine
Office of Medical Education
MN 104 UKMC, 800 Rose Street
Lexington, KY 40536-0298

email : renee.seidel @uky.edu