

VISITING PHYSICIAN ASSISTANT STUDENT APPLICATION

**OFFICE OF THE REGISTRAR
DUKE UNIVERSITY SCHOOL OF MEDICINE**

Duke University School of Medicine
Room 0386, 3rd Floor
Seeley G Mudd Building
8 Searle Center Drive
Box 3878 DUMC
Durham, NC 27710

Scott Campbell, Student Services Officer
and Visiting Student Coordinator
scott.campbell@dm.duke.edu
Phone (919) 684-8042
FAX (919) 684-4322

(Return completed application and all supporting documentation **electronically** to the Visiting Student Coordinator at scott.campbell@duke.edu)

Last Name, First Name, Middle Name:	Date:
Date of Birth:	Country of Citizenship:
Gender:	Clinical Coordinator for Home PA Program:
	Clinical Coordinator email:
	Home PA Program:
Student Mailing Address:	Home PA Program Mailing Address:
Student Telephone Number:	Home PA School Telephone Number:
Student Fax Number:	Home PA School Fax Number:

Rotation(s) desired as listed in Duke School of Medicine Bulletin (**No Duke required rotations permitted**). Please list in order of preference. (**Maximum of 8 weeks**)

PHYASST Course Number	Course Title:	Course Dates Proposed:	Preceptor Identified: (if available)

Statement of the Dean, Program Director or Registrar from the Home PA School

The above named student is in good standing at this institution and is in the ____ year of a _____ year program with an anticipated graduation date of (mm/dd/yyyy)_____. The student will receive academic credit at the home institution for work successfully completed. Personal health insurance and professional liability coverage are in effect while the student is away from the home institution for participation in this program. The amount of professional liability coverage provided is

\$ _____ per occurrence / \$ _____ aggregate.

As required, a copy of the Certificate of Coverage specifying these required limits is provided.

This institution and the student understand this is the only professional liability coverage she/he has while taking an elective at Duke University School of Medicine and must comply with Duke's professional liability coverage requirement of **2 million dollars per occurrence and 5 million dollars aggregate**. If approved for such an elective, the home institution, by signature of this application, agrees to provide the required coverage.

Signature:

Printed Name:

Date:

Title:

(School Seal) **Only original signature and seal accepted.**

Statement of the Visiting Physician Assistant Student

I am aware that acceptance as a Visiting Physician Assistant Student carries no implication concerning formal admission to or matriculation at Duke University School of Medicine. Evaluation of my performance while studying at Duke University School of Medicine is based on the same criteria as those used to evaluate matriculated physician assistant students at Duke. As such, only the Duke University School of Medicine Physician Assistant Evaluation Form will be provided at the end of the approved elective period.

I understand if accepted, a registration fee of **\$300.00** is required prior to my approved start date at Duke. This payment, payable to Duke University School of Medicine, is to be made directly to the Office of the Bursar.

Signature:

Printed Name:

Date:

email address:
