AMERICAN UNIVERSITY OF BEIRUT

FACULTY OF MEDICINE

OFFICE OF THE ASSOCIATE DEAN FOR MEDICAL EDUCATION

Application for Observer Visiting Resident Elective Rotation

Paste recent colored passport-size photograph

Office of Graduate Medical Education,
Faculty of Medicine and Medical Center
Saab Medical Library Bldg., Mi'mari Street
American University of Beirut
Beirut, Lebanon
Tel: 9611350000 Ext: 4526/4706
E-mail: gme_adm@aub.edu.lb or gme@aub.edu.lb

Part I *(to be completed by the resident or clinical fellow applying for elective)*

ELECTIVE CHOICE	Specialty / Sub Specialty	Start Date *(dd/mm/yyyy)*	End Date *(dd/mm/yyyy)*
First Choice			
Second Choice			

APPLICANT INFORMATION

1. **Name** *(print full name in accordance with identity card or passport)*

In English Last First Middle

2. **Birth Date:** _____ *(dd/mm/yyyy)*
3. **Gender:** ☐ Female ☐ Male
4. **Cell phone:** _____
5. **Citizenship:** ☐ Lebanese ☐ Other_____
6. **Current mailing address**

Bldg. Street City Country

E-mail ***(This email address will be used to communicate with you the status of your application)***

ACADEMIC HISTORY

7. **Medical School:** _____
8. **Date Degree Awarded**: _____ *(dd/mm/yyyy)*
9. **List all residency/fellowship training in chronological order, beginning with the most recent institution** *(Do not abbreviate names)*

Dates From *(dd/mm/yyyy)*	Dates To *(dd/mm/yyyy)*	Sponsoring Institution and Address	Program Name	PGY Level

I certify that my answers are true and complete to the best of my knowledge and that I have reviewed the Visiting Resident Policy. I understand that false or misleading information may result in my release from the elective rotation

_____ _____

Resident's Signature **Date**

Part II (to *be completed by the Director of the Training Program in which the Visiting Resident is currently enrolled)*

1. **Resident's Name: _____** 2. **PGY Level: _____**
3. **Current Specialty: _____**
4. **Current training program institute** *(name and address)*

Name of Institution

Street Address **City** **Country** **Zip/Postal Code**

5. **Program Contacts:**

Program Director

Printed Name: _____

Phone: _____

E-Mail: _____

I certify that the resident described in this application is currently in good standing in this program and has been approved to participate in this elective rotation.	
_____ **Program Director's Signature** _____ **Date**	**Please Put the Institution's Seal/Stamp**

IMMUNIZATION REQUIREMENTS

You must attach supporting documentation of all vaccines or titer results. Do not attach original records. Submit photocopies only. Records can not be returned. All immunizations listed below must be current prior to starting rotation electives.

RESIDENT'S PERSONAL INFORMATION			
Resident's Name:		**DOB:**	
Marital status:	○ Single ○ Married ○ Divorced ○ Widowed	**Gender:**	○ M ○ F

IMMUNIZATION INFORMATION					
Tetanus – Diphtheria: Booster shot within the past ten years is required.					
Date of Tetanus - Diphtheria Booster:					
Hepatitis B – Doses one and two given four weeks apart. The third dose should be at least 4 to 6 months after the first dose.					
Date of Vaccine #1:		Date of Vaccine #2:		Date of Vaccine #3:	
Date of Antibody Titer:		Results of Antibody Titer:	○ Positive ○ Negative		
Measles – One of the following is required:					
1. Signed physician's record documenting two immunizations at least 30 days apart					
Date of vaccine #1:		Date of vaccine #2:			
2. Laboratory report of positive immune serum antibody titer		Date of Antibody Titer:			
Mumps – One of the following is required					
1. Signed physician's record documenting immunization		Date of vaccine:			
2. Laboratory report of positive immune serum antibody titer		Date of Antibody Titer:			
Rubella – One of the following is required					
1. Signed physician's record documenting immunization		Date of vaccine:			
2. Laboratory report of positive immune serum antibody titer		Date of Antibody titer:			
Chicken Pox (Varicella) – One of the following required					
1. Laboratory report of a positive immune serum antibody titer		Date of Antibody Titer:			
2. Signed physician's record documenting two immunizations at least one month apart					
Date of Vaccine #1:		Date of Vaccine #2:			
3. History of Disease:					
Tuberculosis–PPD skin test (5tu) within 11 months of program start date. This includes people who received BCG in the					
Date of skin test:		Results at 48-72 hours:	○ Positive ○ Negative _____ mm		
Chest X-ray taken?	○ Yes ○ No	Results of chest x-ray	○ Normal ○ Abnormal *		
Did you take INH / Anti Tuberculosis Treatment?	○ Yes ○ No				
** If Chest X-Ray is abnormal please attach report*					
Hepatitis A (Optional)					
Date of Vaccine #1:		Date of Vaccine #2:			
Meningococcal (Optional)					
Date of Vaccine:					

FORM COMPLETED BY:			
Name of Physician:		**Licensure Number:**	
Signature:		**Date:**	