**Home University Approval Form**

**Section A. APPLICANT DETAILS TO BE COMPLETED BY THE APPLICANT**

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| Applicant’s photo here |

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| **Applicant’s Full Name** | **Elective Application Dates:** |
| **Name of Home Medical School** | **Elective Specialties Applied for:** |
| **City** | **Year of Medical School:** |
| **Country** | **Expected Graduation Date:** |

**Section B. HOME SCHOOL VERIFICATION - TO BE COMPLETED BY THE DEAN OR DESIGNATE OF YOUR MEDICAL SCHOOL**

I certify that the applicant named above is in the \_\_\_\_ year of a \_\_\_-year programme leading to a MD Degree. At the time of the proposed elective this student will be in the \_\_\_\_\_ year and will have completed at least one year of clinical training. He/she is expected to graduate in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (month/year).

I certify that the photograph attached on this form is a true likeness of the applicant.

I certify the applicant will be fully registered as an undergraduate medical student in our medical school at the time of the proposed elective.

I confirm that the above-named medical student is in good standing with this Medical School and I support without reservation his/her request to take part in the Elective Programme at Trinity College Dublin. This student is authorised by our university to undertake this elective and will receive credit for it.

I am not aware of any current or pending disciplinary or legal issues in relation to this student.

Assessment of Character and Conduct: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessment of Academic Ability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is English the language of instruction in your medical school?**

Yes

No

If English is not the principal language of instruction, student must upload TEFL exam results/equivalent as listed on TCD website: <https://www.tcd.ie/study/apply/admission-requirements/undergraduate/index.php>)

**Does your school provide malpractice insurance/ public liability insurance for this student's elective?**

Yes

No

If yes, a copy of insurance cover is attached.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: ++ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Official Stamp of Medical School**: