Elective Application form for Medical Doctor/ Student
At Hospital for Tropical Diseases, Faculty of Tropical Medicine
Mahidol University

Personal Information

Name:		Nationality: Age:
Gender ☐M ☐F	Country of resident	Passport / ID No:
Email address:		Phone number:
Current Address: ……		
Current status: ☐ Medical student ☐ Resident ☐ Fellow ☐ Physician ☐ Other……		Training program/ Major …… …… Year …… Part of medical curriculum? ☐ Yes ☐ No
University/Affiliation: ……		
Requested period	From (DD/MM/YYYY)…… To (DD/MM/YYYY)……Duration:……..…weeks	
Reasons, Expectations and objectives of your visit	…… …… …… …… ……	
Emergency Contact:	Name …… Relationship …… Mobile Phone……..Email ……	

IF ACCEPTED AS A VISITOR, I CERTIFY THAT:

- I shall hold all information that I may obtain directly or indirectly concerning patients, doctors or personnel as absolute confidentiality. I shall not disclose to other persons.
- I shall comply with all rules and regulations of the Hospital for Tropical Diseases as well as the Faculty of Tropical Medicine's and Mahidol University's.
- I understand that my supervisor as well as the Director of the Hospital for Tropical Diseases reserves the right to terminate my elective status at anytime.

I have read each of the above conditions and I agree to be bound by them.

SIGNATURE …… DATE……