ST1 Form

Mahidol University
Faculty of Medicine Siriraj Hospital

PHOTO
Size 1x1.5”

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APPLICATION FOR AN ELECTIVE

FIRST NAME: MIDDLE NAME: LAST NAME:

NATIONALITY: SEX: ☐Male ☐Female DATE OF BIRTH: AGE:

PASSPORT NUMBER: EXPIRY DATE: BLOOD TYPE:

MAILING ADDRESS:

TEL: FAX: EMAIL:

IM APPS ☐WhatsApp ID:……. ☐Line ID:……..……. ☐WeChat ID:…… ☐FB Messenger ID:…….....

MEDICAL SCHOOL: COUNTRY:

ADDRESS:

CURRENT STUDY YEAR: ○ Medical Student ☐1st ☐2nd ☐3rd ☐4th ☐5th ☐6th ☐7th ☐8th

○ Resident ☐1st ☐2nd ☐3rd ☐4th ○Fellow ○ Others ……

○ Graduate Student ☐ Master’s Degree ☐ Ph.D. Degree

PRIOR CLINICAL EXPOSURE: ☐yes ☐no DURATION OF CLINICAL EXPOSURE: years months

PRIOR RESEARCH EXPOSURE: ☐yes ☐no DURATION OF RESEARCH EXPOSURE: years months

LANGUAGE SPOKEN: LENGTH OF INTENDED ELECTIVE: week(s)

INTENDED DATE OF ARRIVAL: INTENDED DATE OF DEPARTURE:

YOUR PREFERENCE OF DEPARTMENT/ AREA OF INTEREST: please find more information via the next page.

1. 2. 3.

CONTACT PERSON IN CASE OF EMERGENCY:

NAME: RELATIONSHP:

TELEPHONE/MOBILE: EMAIL ADDRESS:

***** Please attach all documents requested with this form. *****