College of Medicine

**Visiting Observership Program Application**

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| **General Information** | | | | | | | | |
| Name : | *Iast middle first* | | | | □ Female / □ Male | | | |
| Date of Birth (dd/mm/yyyy) : | | | | | Nationality : | | | |
| Social Security Number : | | | | | Passport Number : | | | |
| E-mail : | | | | | Phone : | | | |
| Academic Year : of - year program | | | | | Expected graduation date(mm/yyyy) : | | | |
| Mailing Address : | | | | | | | | |
| Zipcode : | | | | | | | | |
| Language Proficiency : | | | | | | | | |
| Korean | | □ Elementary | | □ Limited working | | □ Professional working | | □ Native |
| English | | □ Elementary | | □ Limited working | | □ Professional working | | □ Native |
|  | | | | | | | | |
| **Desired Department (in order of preference)** | | | | | | | | |
| 1st Choice | | | Department : | | | | Date :  *dd / mm / yyyy* to *dd / mm / yyyy* | |
| 2nd Choice | | | Department : | | | | Date :  *dd / mm / yyyy* to *dd / mm / yyyy* | |
| 3rd Choice | | | Department : | | | | Date :  *dd / mm / yyyy* to *dd / mm / yyyy* | |
|  | | | | | | | | |
| **Certification by Medical School Official** | | | | | | | | |
| Signature of Medical School Official : | | | | | | | Date of Signature : *dd / mm / yyyy* | |
| Name (print or type) : | | | | | | | Title : | |
| School : | | | | | | | | |
| Address : | | | | | | | | |
| Phone Number : | | | | | | | Fax : | |
| Please affix school seal or stamp here : | | | | | | | | |
|  | | | | | | | | |
| **Declaration** | | | | | | | | |
| I hereby declare that the information provided above is true to the best of my knowledge and will abide by whatever decision College of Medicine Hanyang University makes with regard to my application.  **Signature of Applicant** : | | | | | | | | |
| *Name Signature Date(dd/mm/yyyy)* | | | | | | | | |