Washington University in St.Louis
SCHOOL OF MEDICINE

Diversity Programs

VISITING ELECTIVE PROGRAM- APPLICATION INSTRUCTIONS

Thank you for your interest in the Office of Diversity Programs (ODP) Visiting Elective Program.
Because there are multiple components for this application, our office has put together this brief chart showing each component needed for a complete application, and where to submit each one.

To email materials to our office, please use this email address:

medschooldiversity@wusm.wustl.edu

A complete VEP application consists of the following **components**:

Items Needed:	How to Submit Each Item:
☐ Completed **SUPPLEMENTAL APPLICATION**	-Email to Diversity Programs (ODP)
☐ Curriculum Vitae	-Email to ODP
☐ Completed **RECOMMENDATION FORM**	**-Have RECOMMENDER EMAIL to ODP** (Attach with the recommendation letter)
☐ 1 letter of recommendation on letterhead - from a faculty member	**-Have RECOMMENDER EMAIL to ODP**
☐ Official medical school transcript	**-If you've applied through VSLO, we'll download your transcript**

Please note: The components listed above are also required for the Washington University Emergency Medicine Leadership in Emergency Medicine Diversity Scholarship (WUEM LEaD) , the Groff Diversity Scholars Program in Neurology, and the URiM Sub-Internship Program in Otolaryngology. The medical school transcript should be submitted through VSLO. All other materials should be submitted to the Office of Diversity Programs.

Please feel free to contact us with inquiries via phone (314) 362-6854 or email
medschooldiversity@wusm.wustl.edu

VISITING ELECTIVE PROGRAM- SUPPLEMENTAL APPLICATION
Send applications to: medschooldiversity@wusm.wustl.edu
Transcripts must be submitted through VSLO

1. Name_____ Date_____

2. Medical School_____Expected Grad. Date_____

3. Undergraduate Institution_____Grad. Date_____

4. Date of Birth_____/_____/_____   5. Gender Please select one
                    mm   dd   yyyy

6. Pronouns_____   7. Phone Number_____

8. Email_____

9. U.S. Citizen or Permanent Resident   ◯ Yes

                                           ◯ No   Country of citizenship_____

10. Racial identification or ethnicity (Self-identification is entirely voluntary).

    Please select one

If "Other Hispanic", please specify_____

If "Other", please specify_____

If "multi-racial" or "multi ethnic", please specify_____

11. Do you come from a socioeconomically disadvantaged background? If you answered "yes",
     please describe on a separate page and attach an additional page if necessary.
                    ◯ Yes   ◯ No

12. Are you applying to the Washington University Emergency Medicine Leadership in
     Emergency Medicine Diversity Scholarship (WUEM LEaD)?
                    ◯ Yes   ◯ No

If you answered "yes", we will forward your application to the Division of Emergency Medicine
for review.

13. Are you applying to the Groff Diversity Scholars Program – Dept. of Neurology?
                    ◯ Yes   ◯ No

If you answered "yes", we will forward your application to the Department of Neurology for review.

14. Are you applying to the URiM Sub-Internship Program in Otolaryngology?
                    ◯ Yes   ◯ No

If you answered "yes", we will forward your application to the Department of Otolaryngology for
review.

VISITING ELECTIVE PROGRAM- SUPPLEMENTAL APPLICATION

15. Please list the faculty member from your school who will submit a letter of recommendation. We must receive the letter of recommendation at least four weeks prior to the requested elective start date.

Name_____ Title _____

16. How will taking part in this program further your career goals or professional interests?
    (Minimum of 200 words; please attach an additional page if necessary)

17. If I am not accepted into the Office of Diversity Programs Visiting Elective Program and not offered a stipend, I am still interested in taking an elective at Washington University School of Medicine (select one):

⃝ Yes   ⃝ No

Applicant's Signature_____Date_____

VISITING ELECTIVE PROGRAM- RECOMMENDATION FORM

Send applications to: medschooldiversity@wusm.wustl.edu

To the Applicant:

Please complete the upper portion of this form and forward it to your recommender.

Applicant's name_____   Medical School_____

○ I do waive my right to review the following recommendation

○ I do not waive my right to review the following recommendation

Applicant's signature _____

Recommender's name_____

To the individual submitting the letter of recommendation:

The student listed above requests that you write a letter of recommendation on his or her behalf for the Office of Diversity Programs' Visiting Elective Program. The recommendation, which can be submitted via email, should be submitted with this cover letter to the office listed at the top of the page. Thank you.

Signature_____   Date_____

Title_____

Mailing Address_____

_____

_____

Deadline: Preferably four weeks before the start date of the desired elective
Please email the Office of Diversity Programs at medschooldiversity@wusm.wustl.edu for exceptions.