HUNGARIAN MEDICAL ASSOCIATION OF AMERICA, INC.
BUFFALO, NY, USA, P.O. BOX 337, 14213

STATE UNIVERSITY OF NEW YORK
AT BUFFALO
SCHOOL OF MEDICINE AND BIOMEDICAL SCIENCES

STATE UNIVERSITY OF NEW YORK
HEALTH SCIENCE CENTER
SYRACUSE, NY

SEMMELWEIS UNIVERSITY OF MEDICINE, BUDAPEST
UNIVERSITY MEDICAL SCHOOL, DEBRECEN

ALBERT SZENT-GYÖRGYI MEDICAL UNIVERSITY OF SZEGED
UNIVERSITY MEDICAL SCHOOL, PÉCS

APPLICATION FORM FOR SENIOR STUDENTS FOR 3 MONTH EXCHANGE PROGRAM

SURNAME

GIVEN NAME

DATE OF BIRTH, PLACE

PASSPORT NO.

CITIZENSHIP

PERMANENT ADDRESS

TELEPHONE

FAX

E-MAIL

MEDICAL SCHOOL

PROPOSED PERIOD OF STUDY

FROM DAY / MONTH / YEAR TILL DAY / MONTH / YEAR

PROPOSED PROGRAM (CLINICAL STUDY)

OFFICIAL WRITTEN STATEMENT IN ENGLISH FROM THE UNIVERSITY CONFIRMING THAT THE STUDY PROGRAM WILL BE RECOGNIZED BY YOUR MEDICAL SCHOOL AS PART OF THE CURRICULUM (A LETTER OF ACCEPTANCE FROM THE DEAN)

ANY SCIENTIFIC ACTIVITY, PUBLICATIONS, ETC. GIVE NAME AND PLACE.

STATEMENT OF PURPOSE – INTEREST AND FUTURE PLANS IN MEDICINE. HOW THIS ROTATION WILL CONTRIBUTE TO YOUR MEDICAL WORK IN HUNGARY. USE SEPARATE SHEET OF PAPER IF NECESSARY.

OTHER EXTRACURRICULAR ACTIVITY:

FOREIGN LANGUAGES YOU CAN SPEAK AND READ:

ENGLISH LANGUAGE (TOEFEL) GRADE:

ENCLOSURES FOR THE APPLICATION FORM:

1. CURRICULUM VITAE
2. PASSPORT PHOTO (2)
3. LETTERS OF RECOMMENDATION FROM 2 DIFFERENT DEPARTMENT CHAIRMAN
4. COPY OF INDEX
5. LANGUAGE EXAM CERTIFICATE (Copy)
   (ONLY TOEFEL)

I AGREE, THAT UPON RETURNING TO HUNGARY I WILL SUBMIT A REPORT ABOUT MY CLINICAL STUDY TO THE HUNGARIAN MEDICAL ASSOCIATION OF AMERICA INC. (TWO COPIES AND MY MEDICAL SCHOOL). FAILING TO DO SO, SHALL LEAD TO REIMBURSEMENT OF THE TOTAL AMOUNT OF THE GRANT AWARDS. I ALSO AGREE THAT IN CASE OF NONFULFILLMENT OF THE ROTATION PERIOD, THE FINANCIAL AID WILL BE PAID BACK ACCORDINGLY.

THE HUNGARIAN MEDICAL ASSOCIATION OF AMERICA DOES NOT ACCEPT RESPONSIBILITY FOR ANY INJURY, SICKNESS OR ACCIDENT THAT MIGHT OCCUR DURING THE STAY OF THE CLINICAL PRACTICE, I UNDERSTAND THAT I HAVE TO BUY MY OWN HEALTH INSURANCE.

I, THE UNDERSIGNED, HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE SIGNATURE