



THE CADUCEUS CLUB

UNIVERSITY OF ALBAMA SCHOOL OF MEDICINE

PERSONAL

Date: _____

Name _____ Class: _____

Local Address _____ Zip _____ Telephone _____

Email Address: _____

Date of Birth _____ Soc. Sec. No. _____ Marital Status _____ Children _____

Undergraduate College _____ Home Town _____

Campus Address & Telephone No. (Current) _____

Notify in event of emergency: _____

Hospital Service Next 60 Days Telephone _____

TRAINING PROGRAM

Desirous of Travel to (Institution or Training Site) _____

Address _____

Purpose of Visit (Research, Study, Etc.) _____

Will your visitation be made during elective period _____ or other _____

Departure Date _____ Duration of Stay _____

Living Quarters \$ _____ Meals \$ _____ (These two items are not reimbursed. This is requested simply to determine the total cost of your visit.)

Transportation \$ _____

Are other funds available to you to help defray the total cost of your visit? _____

Source _____

Amount Granted _____ Date _____

Faculty Sponsor _____

Campus Address: _____ Telephone _____

How do you expect the training program to benefit you in your future medical career?

_____ (Use additional page if necessary.)

Anticipated Specialty: _____ Type of Practice _____

Other Comments: _____

THE CONDITIONS OF THE STUDENT TRAVEL FELLOWSHIP HAVE BEEN EXPLAINED TO ME. I UNDERSTAND THAT I MUST MAKE MY OWN TRAVEL ARRANGEMENTS AND THAT I WILL TRAVEL AT MY OWN RISK.

SIGNED

**RETURN APPLICATION TO:
THE SCHOOL OF MEDICINE ALUMNI OFFICE
NO LATER THAN NOVEMBER 1.
811 SOUTH 20TH STREET, BIRMINGHAM, AL 35205
(205)-325-3092**