



Mahidol University

Faculty of Medicine Siriraj Hospital

DIVISION OF INTERNATIONAL RELATIONS
3rd Floor, Building #59 (Jainadnarendhranusorn Building)
2 Wanglang Road, Bangkok-Noi, Bangkok, 10700 Thailand
Tel: 66-2419-9465-6 Fax: 66-2418-1621
e-mail: siirco@mahidol.ac.th, irsiriraj@gmail.com
website: http://www.si.mahidol.ac.th/eng

PHOTO
Size 1x1.5"

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

Residency 1st 2nd 3rd 4th 5th

Fellow 1st 2nd 3rd

Graduate Student Master's Degree Ph.D. Degree

Others

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)



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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.
4.

CONTACT PERSON IN CASE OF EMERGENCY:

NAME: RELATIONSHIP:

TELEPHONE/MOBILE: EMAIL ADDRESS:

BRIEFLY INFORMATION FOR THIS ELECTIVE: Please let us know your expectations on this elective, the reason why you are interested to undertake an elective at our institute, how do you know about our institute etc.