

MUSC

MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Medical University of South Carolina Visiting Student Information Form

Date of Application: _____

Name: _____

Date of Birth: _____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____

What School are you from: _____

Department will you be working with: _____

Department of sponsoring individual: _____

Email of sponsoring individual: _____

Phone number of sponsoring individual: _____

Will you need access to computer systems: _____

Have you ever been convicted of any crimes other than a traffic violation?

Yes: _____ No: _____ If "Yes", explain: _____

Please return this form with all other
Visiting student application materials to
Pamela Troneck, Co-Director of Student Services
Medical University of South Carolina
96 Jonathan Lucas St., Ste. 601
PO Box 250617
Charleston, SC 29425