



University of Seychelles American Institute of Medicine

Student Registration Form

Student Name:

Student I.D:

Name of Rotation:

Start Date:

End Date:

Number of weeks:

Name of Consultant:

Additional Information:

Current E-mail Address

Student Signature _____

Date:

Clinical Coordinator _____

Date:

Please Note: By signing this form, the student is obligated to pay for the services listed above.