AMERICAN UNIVERSITY OF BEIRUT
FACULTY OF MEDICINE

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Application for Shadowing

Faculty of Medicine,
Office of Associate Dean for Medical Education
American University of Beirut,
P.O. Box: 11-0236, Riad El-Solh, Beirut 1107 2020, LEBANON
Tel: 961 1 350000, 340460 ext: 4783
E-mail: ra439@aub.edu.lb

1. **Name (*print full name in accordance with your identity card or passport)***

_____

2. **Parent Medical School**_____ **3. Gender** ☐ **Female** ☐ **Male**

4. **Major:** _____ **5. Citizenship** _____

6. **Current mailing address** ***(the address you provide under this item will be used to communicate to you the status of your application)***

_____

7. **Mobile phone number** _____ **8. Address**_____

_____

9. **Department you are interested to shadow (required)**_____

10. **Physician you are interested to shadow** _____

11. **Period you are interested in (2 weeks)** _____

12. **AUB staff dependent (Yes/No)**_____

If yes, please specify Name and AUB ID number _____