**Departmental Visiting Medical Student Fee Waiver Application**

This form may be used by a School of Medicine department to request application fee waivers for all applicants from LCME accredited schools to the department’s program for individuals under-represented in medicine.

Department/Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Faculty Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your department’s program for medical students underrepresented in medicine from institutions other than Johns Hopkins. Please include (limit 500 words or fewer):

* information about how you recruit participants
* the structure of their educational activities during the rotation
* evaluation of the success of the program
* financial commitment of the department to this program