



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
School of Medicine

Clinical Clerkship Affidavit

I, _____
(Name of Applicant)

a medical graduate of _____,
(Name of Medical School)

☐ did

☐ did not

attend courses/clerkships in the United States during medical school.

List every course/clerkship performed in the United States.

Course/Clerkship	Begin/End Date	Facility/City
Family Practice	_____ to _____	_____
Internal Medicine	_____ to _____	_____
Introduction to Patient/ Physical Examination	_____ to _____	_____
OB/GYN	_____ to _____	_____
Pediatrics	_____ to _____	_____
Psychiatry	_____ to _____	_____
Surgery	_____ to _____	_____
Other (List All)		
_____	_____ to _____	_____
_____	_____ to _____	_____
_____	_____ to _____	_____
_____	_____ to _____	_____
_____	_____ to _____	_____
_____	_____ to _____	_____

Applicant's Signature _____ Date _____
Type Full Name