

## NON-MUSM CLINICAL ELECTIVE REQUEST FORM

A course description and letter from the host institution indicating willingness to accept the student must accompany this form. Form must be completed with all necessary signatures at least four weeks prior to the start of the elective.

**I. This section to be completed by the student**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Elective Name: \_\_\_\_\_

Host Institution and Address: \_\_\_\_\_

Host Preceptor and Phone Number: \_\_\_\_\_

Number of Weeks: \_\_\_\_\_ Inclusive Dates: \_\_\_\_\_

I have or will have completed, prior to the off-campus experience, the following senior clerkships (attach additional sheet if necessary):

Course Name	Location	R or E*	Length of Course	Inclusive Dates

\* Required or Elective

**V. Date:** \_\_\_\_\_ **Student Signature:** \_\_\_\_\_

**II. Student Advisor:**

\_\_\_\_\_ Student **has** permission to proceed with application for this experience.

\_\_\_\_\_ Student **does not have** permission to proceed with application for experience, see attached explanation.

Date: \_\_\_\_\_ Student Advisor \_\_\_\_\_

**III. Department Chairman:**

Department of \_\_\_\_\_

\_\_\_\_\_ Student **has** permission to proceed with application for this experience.

\_\_\_\_\_ Student **does not have** permission to proceed with application for experience, see attached explanation.

Date: \_\_\_\_\_ Chairman \_\_\_\_\_

**IV. Office of Clinical Education:**

\_\_\_\_\_ Student **has** permission to proceed with application for this experience.

\_\_\_\_\_ Student **does not have** permission to proceed with application for experience, see attached explanation.

Date: \_\_\_\_\_ Associate Dean \_\_\_\_\_