UNC SCHOOL OF MEDICINE

AWAY ELECTIVE REQUEST FORM

SECTION I: *(To be completed by the student)*

Student Name: _____ PID: _____

Course Title/Number: _____

Proposed Rotation Dates: _____

SECTION II: *(To be completed by Host Institution Dean of Students or approved designee school official)*

Host Institution Name and Address: _____

Preceptor Name: _____ Preceptor Department: _____

Preceptor E-mail Address: _____

Host Institution Registrar Name and E-mail: _____

The above student has been scheduled for an elective rotation with the host institution *(check one)* ☐ yes ☐ no

Type of elective rotation *(check one)*: ☐ Clinical ☐ Research Approved rotation dates: _____

Number of credit hours: _____ Estimated hours per week: _____

Method of student evaluation *(check one)*: ☐ UNC Evaluation Form ☐ Host Institution Evaluation Form

The student will report to:

Person: _____ Start Date: _____

Place: _____ Time: _____ Phone Number: _____

Host Institution Signature: _____ Title: _____

Please submit completed form (Sections I-II) to the UNC School of Medicine Registrar's Office. Attach course objectives to be reviewed by College/Career Goal Advisor and the Director of Clinical Curriculum.

SECTION III: *(To be completed by UNC School of Medicine Registrar's Office)*

Attach course objectives to be reviewed by College/Career Goal Advisor and the Director of Clinical Curriculum.

College or Career Goal Advisor Signature: _____ Date: _____

Director of Clinical Curriculum Signature: _____ Date: _____

SOM Director of Electives

SECTION IV: (To be completed by UNC School of Medicine Registrar's Office)

Registrar Approval: ☐ Yes ☐ No Signature: _____ Date: _____

☐ one45

☐ ConnectCarolina

☐ Database