STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER
OFFICE OF THE REGISTRAR
BASIC SCIENCE BUILDING 1-112 MSC 98

PROPOSAL FOR EXTRAMURAL / TAILOR-MADE ELECTIVE
COLLEGE OF MEDICINE

INSTRUCTIONS: This form is used to propose an elective on campus (tailor-made) which is not in the Course Selection Book or to obtain approval to receive credit for an elective off-campus (extramural) at another institution. Complete appropriate section for extramural or tailor-made. All required signatures must be obtained and form submitted to the Office of the Registrar in order to be approved and registered. Any form submitted less than two (2) weeks (see Add/Drop Policy in the Course Selection Book) prior to the start of the elective will be charged a $20 late fee paid.

STUDENT NAME: ____________________________  SID: ____________

DESIRED DATES: START __________ END __________  # WEEKS __________

SHOULD BEGIN WITH A MONDAY & END WITH A FRIDAY

TAILOR-MADE (On Campus - Not in Course Selection Book - May be research or specially designed elective)

PROPOSED ELECTIVE TITLE: ____________________________

DEPT: ____________________________  FACULTY PRECEPTOR: ____________________________

PRINT NAME

☐ I UNDERSTAND PRECEPTOR CANNOT BE A RESIDENT OR A FELLOW

TEL #: ____________________________  FAX #: ____________________________  E-MAIL ADDRESS: ____________________________

PROVIDE A DETAILED DESCRIPTION OF THE EDUCATIONAL ACTIVITIES YOU WILL BE PARTICIPATING IN DURING THIS ELECTIVE:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

FACULTY PRECEPTOR’S SIGNATURE: ____________________________  REQUIRED  DATE: ____________

EXTRAMURAL (Off-Campus) ELECTIVE TITLE: ____________________________

Is this an INTERNATIONAL ELECTIVE?  NO ☐  YES ☐

INSTITUTION:

Note: If institution is NOT affiliated with an LCME accredited (US) medical school, description of activities must be completed above.

DEPT: ____________________________  FACULTY PRECEPTOR: ____________________________

ADDRESS EVALUATION FORM TO BE SENT:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

TELEPHONE NUMBER:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

FAX #: ____________________________  E-MAIL ADDRESS: ____________________________

REQUIRED FOR ALL TRANSACTIONS

SUNY DOWNSTATE DEPARTMENT CHAIR: ____________________________  SIGNATURE  DATE: ____________

(CORRESPONDING DEPARTMENT AT SUNY DMC)

CLINICAL ASSISTANT DEAN SIGNATURE: ____________________________  DATE: ____________

STUDENT SIGNATURE: ____________________________  DATE: ____________

FOR OFFICE OF THE REGISTRAR USE ONLY

ENTERED ON DATABASE  __/___/____  COURSE NUMBER ASSIGNED: ____________________________  STAFF INITIALS ____________________________

UPDATED 07/19/2018