STUDENT 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 to be 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 four 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.

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STUDENT NAME: __________________________ SID: __________________

DESIRED DATES: START __________________ END __________________ # WEEKS __________
SCHOOL SHOULD BEGIN WITH A MONDAY & END WITH A FRIDAY

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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: _________________________ PRINT NAME

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

____________________________________________________________________________________

_________________________________________ ____________________________
FACULTY PRECEPTOR’S SIGNATURE: ______________________________ REQUIRED DATE: __________

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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: _________________________

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REQUIRED FOR ALL TRANSACTIONS

SUNY DOWNSTATE DEPARTMENT CHAIR: ________________________________ SIGNATURE

(OR CORRESPONDING DEPARTMENT AT SUNY DMC) ________________________________ DATE: __________

CLINICAL ASSISTANT DEAN SIGNATURE: ________________________________ DATE: __________

_________________________________________ ____________________________
STUDENT SIGNATURE: __________________________________ DATE: __________

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FOR OFFICE OF THE REGISTRAR USE ONLY

ENTERED ON DATABASE: 07/19/16 COURSE NUMBER ASSIGNED: __________

ORIGINAL - REGISTRAR: STUDENT - YELLOW CLINICAL ASST DEAN - BLUE

STAFF INITIALS: __________ 09/2016