

REQUEST FOR AWAY ELECTIVE (Non-LCME)

This form & supporting information must be filed with the Office of Medical Education, Registrar's Office, C1802 at least two months prior to the start of the elective.

Student Name _____

Title of Elective _____

Institution/Location where elective will take place (see reverse if the location is other than an LCME-accredited U.S. Medical School or Penn State COM affiliate site.)

Elective Supervisor or Course Director

Name _____

Title _____

Phone _____

Fax _____

Person who should be contacted regarding the student's evaluation (if different than above)

Name _____

Title _____

Phone _____

Fax _____

Please list contact information via which the College of Medicine may reliably reach you while you are away (e-mail, cell phone, phone where you will be staying, departmental phone, etc.; please list at least two methods if possible)

For electives which are at locations other than LCME-accredited U.S. medical schools or Penn State College of Medicine affiliates, please provide the following documentation.

_____ Course Description. This document should include a detailed description of the educational experiences which will occur on the elective, and a statement detailing the number of hours the student will spend weekly in clinical work.

_____ Course goals and objectives.

_____ A listing of faculty responsible for educational experiences during the elective. This listing must include an individual or individuals who will be on site with the student.

_____ A letter from the course director or supervisor attesting they he/she has reviewed the above documents and that they represent a realistic description of the elective. Note that it is the responsibility of the student to gather the above documents, but the description, goals and objectives should come from the organizers of the elective.

Office of Medical Education, Registrar's Office to complete.

Review assigned to: _____ Date _____

Reviewing faculty member to complete.

I have _____ approved this elective.

_____ disapproved this elective.

Signature _____ Date _____

If the elective was disapproved, please list the reason(s) for disapproval.

Please contact the Associate Dean for Clinical Education if you have a question regarding the review process.