

**UNIVERSITY OF MICHIGAN MEDICAL SCHOOL
M4 ELECTIVE FORM FOR OUTSIDE INSTITUTIONS**

SECTION I: TO BE COMPLETED BY STUDENT

Student Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____

Email Address: _____

Date Submitted: _____

STUDENT STATEMENT OF RESPONSIBILITY

I understand that it is my responsibility to submit this form with all necessary signatures by the deadline. In order to receive credit, I understand that it is my responsibility to ensure that I have U of M medical school and departmental approval before leaving for this elective. I also understand that the elective must be a minimum of 4 weeks and that I must hand carry an evaluation form with me to the rotation. It is also my understanding that I will not receive credit for the rotation until the evaluation forms are received and processed by the Office of Student Programs.

Student Signature: _____

Elective Preferences: (1) _____ (2) _____ (3) _____
(i.e. family outpatient, clinical radiology, pathology)

(You must attach a course description for each elective listed above or your application will not be processed)

Preferred Dates: _____ Alternative Dates: _____

Name of Hospital/Clinic/ Program: _____

Contact Person/Medical Education Coordinator: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

Is this elective sponsored by a U.S. Medical School (yes or no)? _____

If yes, please list name of Medical School: _____

If no, please provide a rationale for this rotation (i.e. working with relative, have family living in area, etc)

If no, please provide professional data on your primary supervisor (please print):

Name _____ Practice/Specialty: _____

Board Certification: _____ License: _____

Name of Medical School/Hospital/Program: _____

Contact Person/Medical Education Coordinator: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

SECTION II: STUDENT GOOD STANDING VERIFICATION BY UNIVERSITY OF MICHIGAN

Name of Student: _____	Academic Grade Level: _____		
Student is in good academic standing	Yes	Student will be receiving credit at home school	Yes
Student is covered by liability insurance	Yes	Student is paying tuition at home school	Yes
Student has personal health insurance	Yes	Student has had all required immunizations	Yes
Student has completed HIPAA training	Yes	Student has received respiratory mask fit test	Yes
University of Michigan School Official: Cynthia Murphy	Title of Official: Academic Program Coordinator		
Signature of Official: _____	Date: _____		

SECTION III: TO BE COMPLETED BY VISITING SCHOOL (please print)

The above named student has been approved to do _____ at your institution. The dates he/she will attend are from _____ to _____. (type of rotation i.e. medicine)
Name of Supervising Physician: _____ (please print)

Rotation includes (check all applicable items): inpatient care outpatient care lecture lab rounds

Approximate number of hours student will work per/week _____

Signature Medical Education Coordinator: _____ (please print) Phone Number: (____) _____

Please complete this section when you have approved our student and return to:
Cindy Murphy, Office of Student Programs,
1301 Catherine Road, C-5124 Medical Science Bldg. I, Ann Arbor, MI 48109-0611
Phone: (734) 936-2608 Fax: (734) 936-3510

University of Michigan Internal Office Use Only

By signing this form I agree this elective is worthy of one month of credit from the University of Michigan Medical School.

Name of Clerkship Director (please print): _____ Department: _____

Clerkship Director Signature: _____ Date: _____

Scheduling Course Code Assigned: _____

Scheduling System Entry Date: _____