COLLEGE OF MEDICINE
SPECIAL ELECTIVE APPLICATION

Student Name: _____ **Student Email (UT):** _____

UT Faculty Name: _____ **Faculty Email:** _____

Campus: ☐ Memphis ☐ Knoxville ☐ Chattanooga ☐ Nashville

Length of Elective: ☐ 2 weeks ☐ 4 weeks

Block: _____ **Start Date:** _____ **End Date:** _____

Academic Department/Division of Proposed Elective: _____

Clinical Site(s): _____

Proposed Course Objectives and Description of Elective:

Student Signature: _____ **Date:** _____

Faculty Signature: _____ **Date:** _____

If the Special Elective falls under one of the 7 core clerkships, approval must be obtained by the Clerkship Director.

Clerkship Director Signature: _____ **Date:** _____

SEND COMPLETED FORM TO: jmcadoo3@uthsc.edu and wdabbs@utmck.edu for approval.

For Office of Medical Education Use Only

UT Faculty status verified by Signature: _____ **Received by Date:** _____

Approved by Signature: _____ **Date:** _____