COLLEGE OF MEDICINE
SPECIAL ELECTIVE CE 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): ____

Program Course Objectives and Description of CE:

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:** ______________________________