Year 4 Self-Designed Elective Form

Instructions

1. The form is on the back of this piece of paper.
2. Please take the time to print legible on this form.
3. The form must be submitted prior to the start of the rotation.
4. If the form is not submitted prior to the start of the rotation, no credit will be issued for the rotation.
5. Make sure you put your name on the document
6. Select only one department as the elective can only be assigned to one department.
7. Fill in all the blanks, as this will assist the OCA in follow up on the evaluation.
8. The preceptor's email address is the most important item on the form. The evaluation should not be sent to the coordinator of the department. The evaluation should go the preceptor.
9. It is not necessary to have the preceptor's signature on the form. If the preceptor emailed you approval to participate in the rotation, print out the email and attach it to the form. You can also send email to the OCA to Laura Willingham at willinla@slu.edu.
10. You must submit a course description of the elective you are participating in at the bottom of the form.
11. If you do not have a course contact's information, simply place N/A (non-applicable) in the box.
12. N/A cannot be used for the preceptor's email address.
13. You must either have your advisor sign this document or have the advisor send an email approval that will be attached to this document.
14. You may print and attach the elective description and objectives if it is available on the away rotation's website.

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Today's Date: _____

Student Name (Please print)	

Please provide **ALL** of the following information requested below.

This elective is a	Direct Patient Care (DPE) Non-Direct Patient Care (NPE) Research (RSE) Senior Inquiry (INQ) Teaching (TE)
This elective will be done primarily in the department of (circle one)	Anesthesiology Emergency Medicine Dermatology Family Medicine Internal Medicine Medical Education Neurology Obstetrics & Gynecology Ophthalmology Orthopaedic Surgery Otolaryngology Pediatrics Psychiatry Radiology Radiation Oncology Surgery Other (please specify) _____

Start Date:		End Date:		Course Length: (# of weeks)

Please provide **ALL** of the following contact information about the elective director.

Faculty Sponsor Name: (First and Last Name)					
Institution:					
Street:					
City:		State:		Zip Code:	
Country:					
Faculty Phone #:		Faculty Fax #:			
Faculty Sponsor Email Address for Evaluation:					
Contact Name:		Contact Phone #:		E-mail:	

Self-Designed course director or educational coordinator approval or you may attach a copy of your approval letter, e-mail or fax

Faculty Sponsor Signature	**Date:**

Advisor's Signature: _____

You must have your advisors approval

Elective Description:

Elective Objectives:

FOR OFFICE USE ONLY:

Dean's Approval: Date: _____ Initials: _____

Schedule change: Date: _____ Initials:_____ Evaluation added:_____