UNIVERSITY OF CENTRAL FLORIDA
COLLEGE OF MEDICINE
FOURTH YEAR (M4)

PETITION FOR EXTRAMURAL ELECTIVE

_____ MDX 8011 SPECIAL CLINICAL STUDY CREDIT FOR EXTRAMURAL CLERKSHIP

_____ MDX 8900 SPECIAL INDEPENDENT/RESEARCH STUDY FOR AWAY CLERKSHIP

This form must be completed and approved 6 weeks prior to the extramural clerkship start date.

Failure to do so may result in a "not for credit" elective month.

- ✓ You must complete all sections of this petition form before you will be registered for the course for credit. (You must be registered in order for liability coverage to be in effect.)
- ✓ No credit will be granted for work for which a student has been paid.
- ✓ Student may not be supervised by a parent or relative.

STUDENT NAME: _____ **PID**: _____

Rotation Start Date: _____ **Rotation End Date:** _____

VSAS Institution: ☐ Yes ☐ No **If no, does the institution require an affiliation agreement to be completed? _____**

Duration of Elective: 4 Weeks 2 Weeks Other: _____

Initial that you understand and/or have completed each of the following:

____ The supervising physician is a faculty member at an accredited medical school/residency program.

____ I understand that it is **my** responsibility to provide the supervising faculty with an evaluation form before the end of the rotation, and to provide them with instructions on submitting the form to the COM.

____ I have arranged for housing for the duration of the rotation.

If you are completing a Special Clinical Study, please complete the following and attach a clerkship description. If this is a non-VSAS institution you must also attach a copy of your acceptance to the program.

_____
Course/Elective Title

_____
Away Institution Name

_____
Address, City, State & Zip Code

_____
Away Institution Supervising Faculty or Contact Person

_____
Away Supervising Faculty or Contact Person E-mail Address Contact Telephone #

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If you are completing a Special Independent/Research Study, please complete the following and attach a copy of the supervising faculty's approval of the terms below (i.e. email correspondence).

Title: _____

Study Question: _____

Background: _____

_____

Anticipated Goals/Outcomes:_____

_____

_____

_____
Away Institution Name

_____
Address, City, State & Zip Code

_____
Away Institution Supervising Faculty or Contact Person

_____
Away Supervising Faculty or Contact Person E-mail Address Contact Telephone #

Student Signature Date

UCF COM Assistant Dean for Medical Education Signature Approval Date

UCF COM Associate or Assistant Dean for Students Signature Approval Date

FOR OFFICE USE: APPROVED_____ PEOPLESOFT_____OASIS_____STUDENT_____DENIED_____