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

___ PETITION FOR SPECIAL CLINICAL STUDY CREDIT @ UCF (MDE 8900)
___ PETITION FOR SPECIAL INDEPENDENT/RESEARCH STUDY CREDIT @ UCF (MDR 8900)

This form must be completed and approved 6 weeks prior to the 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 and obtain all signatures 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:** _____

Duration of Elective: 4 Weeks 2 Weeks Other: _____

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

___ As part of this rotation/study I will be rotating at ___ Nemours Children's Hospital ___ Florida Hospital ___Flagler___ Orlando Health ___Orlando VA ___ I will not be rotating at a local hospital as part of this rotation/study.

___ If you will be rotating at one of the above hospitals, please initial that you have reviewed the credentialing requirements found here: https://webcourses.ucf.edu/courses/981501/pages/credentialing-paperwork.

___ I have discussed first day reporting instructions with the supervising physician, as well as any requirements expected to be completed by me prior to the first day of the rotation.

If you are completing a Special Clinical Study, please complete the following and attach a clerkship description.

_____
Course/Elective Title

_____
Institution Name

_____
Address, City, State & Zip Code

_____ _____
Institution Supervising Faculty or Contact Person (Print) Signature for Approval

_____ _____
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.

Title: _____

Study Question: _____

Background: _____

_____

Anticipated Goals/Outcomes:_____

_____

_____

_____

Supervising Faculty (Print) Signature for Approval

_____

Supervising Faculty 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_____