



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: \_\_\_\_\_

VSLO 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-VSLO 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 Director of M3/M4 Electives Signature Approval

\_\_\_\_\_

Date

\_\_\_\_\_

UCF COM Associate or Assistant Dean for Students Signature Approval

\_\_\_\_\_

Date

FOR OFFICE USE: APPROVED \_\_\_\_\_ PEOPLESFT \_\_\_\_\_ OASIS \_\_\_\_\_ STUDENT \_\_\_\_\_ DENIED \_\_\_\_\_