

Date Submitted: _____

Name of Student _____ Student ID # _____ Class of _____

Title of Proposed Elective _____

Coordinator _____ Department/Subspecialty _____

Location _____ Proposed Month(s) _____

- STUDY PLAN -

Objective(s) _____

Detailed Description of Proposed Independent Study (include work hours/day, days/week, calls/month, etc.)

Planned Resources (Books, Internet, etc.) _____

Evaluation Methods (Written/oral exam, paper, clinical, etc.) _____

STUDENT SIGNATURE: _____ DATE: _____

COORDINATOR'S SIGNATURE: _____ DATE: _____

I agree to supervise this medical student for this independent study course to assist him/her in reaching the stated objectives using the plan, resources and evaluation methods as described above.

- WSU SCHOOL OF MEDICINE USE ONLY -

Documentation from coordinator RECEIVED YES NO

Approved Assistant Dean for Clinical Education _____ DATE: _____