

Date Submitted: _____

Name of Student _____ Student ID # _____ Class of _____

Title of Proposed Elective _____

Preceptor _____ Department/Subspecialty _____

Complete Address _____ 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: _____

PRECEPTOR'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 Preceptor RECEIVED YES NO

Approved Assistant Dean for Clinical Education _____ DATE: _____

Please return this form to Mrs. JaEsta Jones, Supervisor, Office of Records and Registration,
WSU School of Medicine, Ste 318 Richard Mazurek Educ. Commons, 320 E. Canfield
Detroit, MI 48201 Fax Number: (313) 577-3434