Electives at Non-WSU Affiliated Institutions Form

Student Name: _______________________
Student ID#: _______________________
Date Submitted: ____________________

Student Address: __________________________________________
Dates of Elective: _______ to _______

Student Telephone #: ______________________
Student Email address: ________________________

Type of Elective (Please check one):

1. Domestic (U.S)
   A. Established Rotation  
   B. Independent Study  

   Provide the information requested below AND
   Description of Proposed Independent Study Form

2. International
   A. Established Rotation  
   B. Independent Study  

   Provide the information requested below AND
   Description of Proposed Independent Study Form

(Away Institution, Course, and Responsible Faculty Information including mailing address, phone number and email Section)

(Approvals Section)

Faculty Advisor and WSU Department __________________________________________ Date:__________________

For International Electives: Director of Global Health and Education __________________________ Date:__________________

For Domestic Electives: Assistant Dean of Clinical Sciences ____________________________ Date:__________________

Office of Records and Registration
Richard J. Mazurek, MD Medical Education Commons
320 E. Canfield Ave., Suite 315
Detroit, MI 48201
313-577-1470 (phone)
313-577-3434 (fax)
Description of Proposed Independent Study Form

Date Submitted: __________  Student Name: __________________________  Class of: __________

Title of Proposed Elective: ________________________________________________________________

Objectives:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Detailed Description of Proposed Independent Study:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Work Hours (hours/day, days/week, calls/month): _____________________________________________

Planned Resources (Textbooks, books, articles, electronic resources, etc.): ________________________
___________________________________________________________________________________

Evaluation Methods (Written/oral exam, clinical, etc.): _________________________________________
___________________________________________________________________________________

Student Signature: ____________________________________________  Date: ____________________

Supervisor: ____________________________________________  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.

For International Electives: Approved by Director of Global Health and Education _______________  Date: __________

For Domestic Electives: Approved by Assistant Dean of Clinical Sciences ________________________  Date: __________

Please keep a copy of these forms for yourself and turn one copy to Office of Records and Registration and one copy to the Office of Global Health and Education.