Senior Elective Request

RETURN TO:

Records & Registration Office
318 Mazurek Medical Education Commons
320 East Canfield
Detroit, Michigan 48201
313 577-1470
Fax-313 577-3434

SECTION 1
To be completed by student and returned to Office of Student Affairs.

To:

SCHOOL

ADDRESS (STREET) (CITY) (STATE) (ZIP)

DEPARTMENT (SPECIFY)

Telephone NO

I would like to apply for _______________ in your department during the period ___________ to _____________ 19

STUDENT’S NAME

WSU ID#

TELEPHONE NO.

STUDENT’S MAILING ADDRESS

SECTION 2
ELECTIVE IS APPROVED BY

Academic and Student Programs

WAYNE STATE UNIVERSITY

DEPARTMENT

SCHOOL OF MEDICINE

DATE

SECTION 3
The student named above is a fourth/third year medical student in good standing at this institution. The student will pay tuition at this school during the period indicated. Malpractice and personal health insurance are in effect while this student is on this elective. At the conclusion of this experience, a report will be required.

Authorized by: __________________________ Date: __________________________

OFFICE OF STUDENT AFFAIRS, WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE

SECTION 4
To be completed by the host department where student will take elective:

☐ Elective Confirmed

Course Title

Number

Dates:

From

To

THE STUDENT SHOULD REPORT TO:

PLACE

DATE AND TIME

☐ AM

☐ PM

ACCEPTANCE CONFIRMED BY

DATE

DEPARTMENT

SECTION 5
Final approval by WSU School of Medicine 4 Committee

SIGNATURE

DATE