

COLUMBIA UNIVERSITY
COLLEGE OF PHYSICIANS & SURGEONS
OFFICE OF THE ASSOCIATE DEAN
OF STUDENT AFFAIRS

EXTRAMURAL ELECTIVE REQUEST FORM

DATE SUBMITTED: _____

NAME: _____

GRADUATION YEAR: _____

E-MAIL ADDRESS: _____

PHONE NUMBER: _____

I AM APPLYING FOR THE FOLLOWING EXTRAMURAL ELECTIVE PROGRAM:

REQUIRED: TYPE OF ELECTIVE: CONSULT SUB-INTERNSHIP RESEARCH PRECEPTORSHIP

HOSPITAL BASED:

MEDICAL SCHOOL: _____

HOSPITAL: _____

DEPT: _____ SUBSPECIALTY SERVICE: _____

REQUESTED DATES/MONTH FOR ELECTIVE: _____

NON-HOSPITAL BASED:

UNIVERSITY AFFILIATE? YES NO

LOCATION: _____ ELECTIVE: _____

SPONSOR'S NAME: _____

REQUESTED DATES/MONTH FOR ELECTIVE: _____

PROGRAM CONTACT INFORMATION (THE PRECISE MAILING ADDRESS IS REQUIRED):

NAME: _____ TITLE: _____

INSTITUTION: _____

ADDRESS: _____

PHONE: _____ FAX: _____

STUDENT SIGNATURE

NOTE: THE PROCESSING TIME FOR THIS FORM IS ONE WEEK. (ALL ELECTIVES MUST BE AT LEAST FOUR WEEKS IN DURATION, WITH THE EXCEPTION OF UNIVERSITY OF CALIFORNIA SCHOOLS THAT ARE THREE WEEKS.) TRANSCRIPTS, SCHOOL SEALS, THIRD YEAR CLERKSHIP DATES, AND HEALTH/IMMUNIZATION RECORDS MAY ALSO BE REQUIRED AND ARE THE RESPONSIBILITY OF THE STUDENT. IT IS ALSO THE STUDENT'S RESPONSIBILITY TO SEE THAT OFFICE OF STUDENT AFFAIRS RECEIVES CONFIRMATION FROM THE INSTITUTION FOR THE ELECTIVE. YOU ARE NOT OFFICIALLY SIGNED UP FOR THE ELECTIVE UNTIL WE HAVE WRITTEN CONFIRMATION. YOU WILL NOT RECEIVE CREDIT IF CONFIRMATION IS NOT RECEIVED. THANK YOU.

REV 3/21/2006