

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

PERMISSION TO *ENROLL* IN A FOURTH YEAR PRECEPTORSHIP

DATE: _____

STUDENT: _____

E-MAIL ADDRESS: _____

COURSE DIRECTOR: _____

SPECIALTY: _____

MONTH/YEAR: _____

MEDICAL CENTER NAME AND LOCATION: _____

OBJECTIVES: _____

LEARNING EXPERIENCE: _____

FEEDBACK & SUPERVISION: _____

METHODS OF EVALUATION: _____

FOR THE COURSE DIRECTOR

*I have agreed to accept _____ (student) to participate in the indicated elective for _____ (month/ year). At the conclusion of the elective, an evaluation of the student's performance will be returned to the Office of Student Affairs (P&S 3-401). Additionally, Student is responsible for ensuring that an evaluation is on file **NO LATER THAN TWO WEEKS AFTER THE END OF THE ELECTIVE.***

FACULTY MEMBER SIGNATURE

FACULTY MEMBER ADDRESS AND CONTACT PHONE NUMBER

FOR THE SENIOR ASSOCIATE DEAN OF STUDENT AFFAIRS

Student has met with me to discuss adding the above elective. I have granted my approval to do so.

LISA A. MELLMAN, M.D.
SENIOR ASSOCIATE DEAN FOR STUDENT AFFAIRS