



Student Name:	Student ID:	Expected Graduation Year:
---------------	-------------	---------------------------

Title:	Start Date:	End Date:	Total # of Weeks:
Institution Name:	Address:	City: Country:	
Sponsor Name:	Sponsor Email:		
Elective Brief Description:			
Elective Objectives & Goals:			

(Step 1): Sponsor's Name: _____
Sponsor's Signature: _____
Date : _____

(Step 2): Assist/Assoc Dean for Clinical Curriculum Signature: _____
Date: _____

OR (Step 2): in case the elective is a research elective
 Director of Student Research Signature: _____
 Date: _____

- The independent elective must be at least 2 weeks and no more than 4 weeks long.
- Use one form for each elective to which you are applying.
- Students must get approval to do the elective 2 months before the elective starts.

Please return to:
Office of the Registrar / Student Affairs Tel: 44 928 8514 / Fax: 44 928 5222