COLLEGE OF MEDICINE
RESEARCH ELECTIVE APPLICATION

Student Name: _____________________________ Student Email (UT): _________________________________

UT Faculty Name: ___________________________ Faculty Email: _____________________________________

Campus:  [ ] Memphis  [ ] Knoxville  [ ] Chattanooga  [ ] Nashville

Length of Elective:  [ ] 2 weeks  [ ] 4 weeks

Block: _________________       Start Date:  _________________      End Date: __________________

Academic Department/Division: _________________________    Research Site: __________________________

IRB Approval (if working with human subjects):   [ ] Yes  [ ] No

Project Description/Target Population:


Project Objective:


Student Signature: _________________________________________ Date: ____________________________

Faculty Signature: __________________________________________ Date: ____________________________

SEND COMPELTED FORM TO: imcadoo3@uthsc.edu and kbettin@uthsc.edu for approval.

For Office of Medical Education Use Only

UT Faculty status verified by Signature: _________________________ Received by Date: __________________

Approved by Signature: ____________________________________________________________