COLLEGE OF MEDICINE
SPECIAL ELECTIVE APPLICATION

Student Name: _____ Student Email (UT): _____

UT Faculty Name: _____ Faculty UTHSC Net ID: _____

Faculty Preferred E-Mail: _____

Campus: ☐ Memphis ☐ Chattanooga ☐ Knoxville ☐ Jackson ☐ Nashville

Length of Elective: ☐ 2 weeks ☐ 4 weeks

Block: _____ Start Date: _____ End Date: _____

Academic Department/Division of Proposed Elective: _____

Clinical Site(s): _____

Proposed Course Objectives and Description of Elective:

Student Signature: _____ Date: _____

Faculty Signature: _____ Date: _____

If the Special Elective falls under one of the 7 core clerkships, approval must be obtained by the Clerkship Director.

Clerkship Director Signature: _____ Date: _____

SEND COMPLETED FORM TO: jmcadoo3@uthsc.edu and wdabbs@uthsc.edu for approval.

For Office of Medical Education Use Only

UT Faculty status verified by Signature: _____ Received by Date: _____

Approved by Signature: _____ Date: _____

Updated 7/1/25