COLLEGE OF MEDICINE
SPECIAL 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 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: imcadoo3@uthsc.edu and wdabbs@utmck.edu for approval.

For Office of Medical Education Use Only

UT Faculty status verified by Signature: __________________________ Received by Date: ________________

Approved by Signature: __________________________ Date: ________________