COLLEGE OF MEDICINE
SPECIAL ELECTIVE JI APPLICATION

Student Name: _____________________________  Student Email (UT): _________________________________

UT Faculty Name: ___________________________  Faculty Email: _____________________________________

Campus: □ Memphis  □ Knoxville  □ Chattanooga  □ Nashville

Block: _________________  Start Date: _________________  End Date: _________________

Academic Department/Division of Proposed Elective: _______________________________________________

Clinical Site(s): _______________________________________________________________________________

Proposed Course Objectives and Description of Junior Internship:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

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: _____________________________