

**ELECTIVE APPLICATION
FOR MEDICAL STUDENTS NOT REGISTERED AT THE UNIVERSITY OF
MISSISSIPPI SCHOOL OF MEDICINE**

This form must be returned to:

**DIVISION OF STUDENT RECORDS AND REGISTRAR
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 NORTH STATE STREET
JACKSON, MISSISSIPPI 39216-4505**

APPLICATION:

1. Name of Applicant _____
Please Print

2. Mailing Address _____
_____ **Phone Number** _____

3. Name & Address of Next of Kin _____

4. Currently Enrolled as a _____ **year student at** _____
_____ **Medical School**

5. Application for elective in:
(a) _____
(b) _____

6. Dates of requested visit at UMC:
(a) _____
(b) _____

7. Signature of Applicant _____
Date: _____

APPROVAL To be completed by the Dean's office of the medical school where the student is enrolled.

8. The medical student named in item 1 is in good standing at this institution. He/She is approved to take this elective _____ for credit _____ not for credit. Malpractice insurance _____ does _____ does not cover the student away from our school while taking approved work. At the conclusion of the elective, an evaluation report _____ will _____ will not be required within two weeks of the completion of the elective.

9. _____
Signature

Title

School

Address

Date _____ School Seal _____

ACTION To be completed by Elective Department Chairman of the applicant's medical school and returned to the University of Mississippi.

10. Elective mentioned in item 5 for the period specified in item 6 _____ is _____ is not approved.

11. _____
Signature

Title

School

Address

Date _____