

**HOWARD UNIVERSITY SCHOOL OF MEDICINE
APPLICATION FOR INTERNATIONAL ELECTIVE**

One of our medical students (Section 1) is interested in pursuing an elective at your institution. Please complete Section II and III of this form and return it to the medical student listed below. Upon completion of the elective a written evaluation with narrative comments is required. The student will give the course director an evaluation form with a return address. To receive academic credit, students must register with you one-month prior to beginning the course.

SECTION I: (To be completed by the student)

Student Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (____) _____ Student's e-mail address: _____
Title of Elective: _____

The student must provide on separate pages the institutional description of the elective

SECTION II: (To be completed by accepting institution.)

Name of Institution: _____
Address: _____
City: _____ Country: _____ Zip or Postal Code: _____
Phone: (____) _____ Fax: (____) _____ e-mail address: _____
Web Site: _____

SECTION III: (To be completed by accepting institution.)

The above mentioned student has been accepted for the following elective:
Elective title: _____
Dates accepted for: _____
Print name and title of Director for the above elective: _____
Phone number for Director: (____) _____ Fax: (____) _____ email: _____
Print name and title of person completing this form: _____
Phone number of person completing this form: (____) _____ email: _____
Approval – Signed (Director of Elective) _____

SECTION IV: FOR USE AT HOWARD UNIVERSITY COLLEGE OF MEDICINE

Name of Chair of appropriate department _____
Signature (Chair) _____
Approved: _____ Not approved _____ Date: _____
Associate Dean for Academic Affairs: Approved: _____ Not approved: _____ Date _____
Signature: _____ Date: _____