

**UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA
APPLICATION FOR ELECTIVE**

SECTION I TO BE COMPLETED BY STUDENT

Name _____ E-Mail _____ Phone _____ SS# _____

Address _____
Street _____ City _____ State _____ Zip _____

Birth Date _____ 1st initial of mother's maiden name _____ (For security clearance regarding computer access)

Course for which application is made: (in order of preference) Dates for which application is made: (in order of preference)

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____

Are you interested in a residency at UICOM-P: Yes No Specialty _____

Please indicate if you will need housing: Yes No

Student's Signature _____ Date _____

Clerkships you will have completed prior to the start of the elective requested:

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> Medicine | <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Family Medicine |

SECTION II CERTIFICATION BY DEAN OF STUDENT'S MEDICAL SCHOOL

The medical student named above attends an institution accredited by the Liaison Committee on Medical Education (**LCME**) or the American Osteopathic Association (AOA), is in good standing at this school and will be in the **fourth year** of medical school at the start of the requested elective. The student (will) (will not) have completed the clerkships as indicated above at the start of the requested elective. The student (will) (will not) pay tuition at this school during the period indicated. The student (is) (is not) covered by malpractice insurance while away from this school. Personal health coverage (is) (is not) in effect while away from this school. The student (has) (has not) had universal precautions training. The student is authorized to take this clerkship/externship. At the conclusion of the course an evaluation (will) (will not) be required. (Please attach form if require.)

Signature _____ Title _____

School _____ Phone _____

Address _____
Street _____ City _____ State _____ Zip _____

Please return this form to Sandy McGee, Office of Academic Affairs, University of Illinois College of Medicine at Peoria, P. O. Box 1649, Peoria, Illinois 61656 after Section I and Section II have been completed.

SECTION III TO BE COMPLETED BY DEPARTMENT HEAD/CHAIR OF THE ELECTIVE APPLIED FOR AT THE UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA

The above named student is approved for participation in (Course Title) _____

(Course Number) _____ for the period of (Dates) _____. The student will report to:

Person _____ Date _____

Place _____ Time _____

Students from institutions other than the University of Illinois engaged in courses of clinical instruction at the University of Illinois are not covered under the Self-Insurance Program for medical professional liability unless prior written authorization exists.

Signed _____ Title _____ Date _____

SECTION IV TO BE COMPLETED BY THE ASSOCIATE DEAN FOR ACADEMIC AFFAIRS, UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA

The request of _____ for the elective and dates recorded in Section III is approved.

Signature _____ Date _____

Associate Dean for Academic Affairs