

RESEARCH DATES: FROM _____ TO _____

NUMBER OF WEEKS ELECTIVE CREDIT REQUESTED: _____

STUDENT'S SIGNATURE: _____ **DATE:** _____

SECTION 2: (To be completed by the preceptor)		
_____	_____	_____
Title	First Name	Last Name
Department: _____		
Telephone # _____	Email address: _____	

In-House Location-Building	Room/Floor Number	Hospital/Medical School Address
I agree to supervise this student in the performance of the research elective described above, including the design, execution and report of the project.		
PRECEPTOR'S SIGNATURE: _____ DATE: _____		

OFFICE USE ONLY	
Approved: _____ yes _____ no	NUMBER OF WEEKS ELECTIVE CREDIT: _____
COMMENTS: _____	

SIGNATURE: _____	DATE: _____
Senior Associate Dean for Education	

Return this form to The Office of Registration/Student Records (SLH4-44N)