NYU Grossman School of Medicine

APPLICATION FOR RESEARCH ELECTIVE CREDIT

Name: _____ Class: _____

Address: _____ Cell Phone: _____

APPLICATION INSTRUCTIONS

1. Complete all the required information in Sections 1 and 2 of the application.
2. Provide a full description of the research project. The description should encompass the relevant details of the project, be no less than two or three paragraphs in length and clearly state your role in the project.
3. The application must be signed by the supervising preceptor.
4. Return the completed application no less than two weeks prior to the beginning date of the project. Applications submitted after that will not be accepted.
5. Applications submitted with insufficient data will be returned to the student.
6. **In addition to your 12-week Concentration,** you may request a maximum of 12-weeks of research elective credit out of the required 20-weeks of elective credit. However, the minimum number of weeks necessary to complete the Honors Program is 20-weeks (8-weeks completed in the summer between years 1 and 2 plus 12-weeks of elective time OR 12-weeks of concentration plus 8-weeks of elective time).

SECTION 1 (To be completed by the student)

Project Title: _____

Department: _____

Project Description:

Research Dates: From _____ (mm/dd/yyyy) To _____ (mm/dd/yyyy)

Number of weeks elective credit requested: _____

Student's Signature: _____ Date: _____ (mm/dd/yyyy)

APPLICATION CONTINUES

DC 2/10/2021

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SECTION 2 (To be completed by the preceptor):

Title: _____ Name: _____
First Last

Department: _____

Telephone: _____ Email: _____

Location: _____ Address: _____
(In-House Location / Building) (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: _____
(mm/dd/yyyy)

OFFICE USE ONLY

Approved: ◯ Yes ◯ No Number of weeks elective credit: _____

Comments:

Signature: _____ Date: _____
Senior Associate Dean for Medical Education (mm/dd/yyyy)

PLEASE SUBMIT BY EMAIL, FAX OR IN-PERSON TO THE INFORMATION PROVIDED BELOW

Registration & Student Records 550 1st Avenue, Medical Science Building, Suite G90, NY, NY 10016 Tel: (212) 263-5291 Fax: (212) 263-5264 E: Janet.Montero@nyulangone.org