UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA
APPLICATION FOR ELECTIVE

SECTION I TO BE COMPLETED BY STUDENT **Will you be an M4 at the start of this elective ____Yes ____ No**

Name______________________________ E-Mail______________________________
First MI Last

Address______________________________
Street City State Zip

Birth Date________________ Male ____ Female ____ Phone____________________ SS#____________________

1st initial of mother's maiden name_______ (For security clearance regarding computer access)

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

1. ______________________________
2. ______________________________
3. ______________________________

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

1. ______________________________
2. ______________________________
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:

☐ Medicine ☐ Obstetrics/Gynecology ☐ Pediatrics
☐ Surgery ☐ Psychiatry ☐ Family Medicine

SECTION II CERTIFICATION BY DEAN OF STUDENT'S MEDICAL SCHOOL

The medical student named above (is) (is not) attending an institution accredited by the Liaison Committee on Medical Education (**LCME**) or the American Osteopathic Association (**AOA**), (is) (is not) in good standing at this school and (will) (will not) 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 (is) (is not) HIPAA compliant. The student (has) (has not) completed universal precautions training. The student (is) (is not) authorized to take this clerkship/externship. At the conclusion of the course an evaluation (will) (will not) be required. (Please attach form if required.)

Signature______________________________ Title______________________________

School______________________________ Phone____________________

Address______________________________
Street City State Zip

After Section I and Section II have been completed, please return this form to: Chris Finson, Office of Academic Affairs, University of Illinois College of Medicine at Peoria, Box 1649, Peoria, Illinois 61656-1649.

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