

Individually Designed Selective/Elective Form

The Brody School of Medicine at East Carolina University
Greenville, North Carolina 27834

The Office of Student Affairs must receive the **completed form with approvals TWO MONTHS IN ADVANCE**. If this procedure is not followed, the student will not receive credit for the selective.

Please **Print/Type** the Following Information

Student's Name _____ Student's Pager Number _____

Title of Selective: _____

Name of Course Director/Preceptor: _____

Address/Location of Selective: (Name of Location) _____

(Street/PO Box) _____

(City/State/Zip) _____

Telephone Number: _____ Fax Number: _____

Report To (address and time to report on day one) _____

Duration of Course: (check one) _____ 2 weeks or _____ 4 weeks

Block # _____ Dates: From _____ to _____

Overall Course Goal:

Educational Objectives: (Min of 3)

1.

2.

3.

Reading Course Readings:

The following materials will be used: assignments will be as individualized.

Describe the course activities:

- Lectures, clinics, conferences to be attended?
- In what location will students be observed on this elective?
- How will students receive mid-course, formative feedback o their performance?
- Oral presentation, written assignments required?
- Research requirement?

Describe on call requirements, if applicable (including specific duty hours):

Describe how student performance will be assessed and how the course grade will be determined:

Please provide any other pertinent information below:

 I certify that this course will be directed by the identified Course Director or Preceptor, who is member of the faculty of the Brody School of Medicine or has otherwise been approved to direct this activity. I also certify that the department will provide the needed resources to conduct this during the rotation blocks show

Student's Signature: _____ Date _____

Department Chair Signature: _____ Date _____

Course Director or Preceptor/BSOM Signature: _____ Date _____

Course Director or Preceptor/SITE Signature: _____ Date _____

M4 Curriculum Committee Approval: _____ Date _____
(Signature)

This Selective will meet the following requirement: (Check all that apply)		
Primary Care _____	Ambulatory _____	Elective _____

Please Return To: The Brody School of Medicine at East Carolina University
 Office of Student Affairs, Brody 2S-20
 Greenville, NC 27834
 Telephone: (252) 744-2278 Fax: (252) 744-3250