



# INDIANA UNIVERSITY

OFFICE OF UNDERGRADUATE  
MEDICAL EDUCATION

School of Medicine

## Special Elective Request Form

(for electives not in the IUSM Elective Catalog OR other LCME approved institutional catalog)

**Note: One Special Elective Request must be completed for each special elective requested**

Non-LCME accredited medical school special electives require the completion of an Instructor and Course Addenda. International special electives require the submission of an International Special Elective Addendum.

1. Is this elective an elective that is offered by another LCME accredited school?      Yes      No

**Forms should be submitted to the Dean’s Office for Medical Student Affairs, Student Records Section: Medical Sciences Building, Room 118, no later than 1 month prior to the elective start date. For non-LCME accredited institutions and international, forms should be completed and submitted no later than 2 months prior to the start date of the elective.**

Final approval of this request will be made by the Dean’s Office for Medical Student Affairs after approval of those indicated above and completion of all necessary requirements.

- 2. Submission Date: \_\_\_\_\_
- 3. Student Name (Last Name, First Name, Middle Initial): \_\_\_\_\_
- 4. Student Email: \_\_\_\_\_ Phone: \_\_\_\_\_
- 5. Inclusive Start Date (MM/DD/YY): \_\_\_\_\_ Inclusive End Date (MM/DD/YY): \_\_\_\_\_
- 6. Course Title (if any): \_\_\_\_\_
- 7. Discipline of Course Offering: \_\_\_\_\_
- 8. Course Director: \_\_\_\_\_
- 9. Telephone: \_\_\_\_\_
- 10. Location: \_\_\_\_\_
- 11. Address: \_\_\_\_\_
- 12. Course Director Email: \_\_\_\_\_
- 13. Proposal Contact (if different from above): \_\_\_\_\_  
Name/Phone/Email: \_\_\_\_\_

14. Elective Type/Category (Choose One):

PD - Professional Development

AS – Advanced Science/Research (if Research, fill in Research Project Description and Student’s Expected Role in Project)

CP – Clinical Practice

15. Student’s Expected Role in Project (only if AS is chosen above) – attach longer descriptions if needed:

16. Course Description (from the Course Director) – attach longer descriptions if needed:

17. Course Objectives:

18. Duty Hours (include days/times):

19. Assessment Methods:

\_\_\_\_\_ Clinical Performance Evaluation (i.e. <https://iu.box.com/s/bewmvsud2anoebadoqe2>)

\_\_\_\_\_ Research Evaluation Form (i.e. <https://iu.box.com/s/fwh6a2klwk685h1bmeh9>)

\_\_\_\_\_ Other (Attach sample(s) of the assessment rubrics used in the elective)

Course Director Signature \_\_\_\_\_ Date \_\_\_\_\_

IUSM Department Chair Signature \_\_\_\_\_ Date \_\_\_\_\_

Faculty Advisor (fourth year students only) \_\_\_\_\_ Date \_\_\_\_\_

NOTE: Email approvals are accepted in lieu of actual signatures for the IUSM Department Chair, Course Director, and Faculty Advisor and may be appended to the request form.

Is the Director of Medical Education aware of and accepting of the offering?                      Yes                      No

<b>OFFICE USE ONLY – APPROVALS</b>			
Dean's Office – Medical Student Affairs	Date _____	Course#: 93 _____ 990	
Elective Subcommittee	Date _____	Approved _____	Declined _____