

ELECTIVE / CLERKSHIP COURSE DESCRIPTION

University of Missouri-Kansas City School of Medicine
Council on Curriculum

2411 Holmes Street, Kansas City, MO 64108

Return by email to Jenny Brewer: brewerj@umkc.edu (FAX 816.235.1851)

Completed Course Description must be received in the Curriculum Office before student leaves for out of town/country elective experience. Failure to do so **may** result in "not for credit" medicine elective month

STUDENT NAME: _____ MONTH /YR REQUESTED: _____

ELECTIVE TITLE _____

INSTITUTION NAME: _____

ADDRESS: _____

CONTACT PERSON: _____

Phone Number: _____ E-mail: _____

EVALUATOR NAME: _____

Phone Number: _____ E-mail: _____

EDUCATIONAL BACKGROUND _____

MEDICAL _____

RESIDENCY TRAINING _____

HOSPITAL INSTITUTION _____

SPECIALITY CERTIFICATION _____

ACADEMIC APPOINTMENT (IF APPLICABLE) _____

YEARS IN PRACTICE (IF APPLICABLE) _____

You may attach curriculum vitae to simplify your data entry. (Only need to attach the first 4 or 5 pages.)

ELECTIVE PRIMARILY BASED: INSTITUTION OFFICE HOSPITAL STIPEND? YES NO

DURATION OF ELECTIVE: _____ WEEK(S) MONTH(S) HOUSING? YES NO

MEALS? YES NO

INTERVIEW? YES NO

MAXIMUM NUMBER OF STUDENTS: _____

YEAR LEVEL ACCEPTED FOR THIS ELECTIVE: MS-3 MS-4 MS-5 MS-6

IS CALL EXPECTED? YES NO (IF YES, FREQUENCY)

PREREQUISITES? YES NO (IF YES, LIST)

EDUCATIONAL OBJECTIVES: (Briefly described the facts, concepts, skills the student is expected to know upon completion)

1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____
11	_____
12	_____

TEACHING METHODS: (Approximately what % of students time is spent in each of the following?)

_____ % OUTPATIENT VISITS
 _____ HOSPITAL/ROUNDS/PATIENT CARE
 _____ OPERATING ROOM
 _____ LABORATORY
 _____ LECTURE /CONFERENCE
 _____ OTHER (PLEASE SPECIFY BELOW)

METHOD OF EVALUATION: (Check all that apply)

_____ % HANDS ON TRAINING
 _____ OBSERVATION ONLY

 CLINICAL PERFORMANCE
 READING ASSIGNMENTS
 ORAL PRESENTATION
 EXAMINATIONS
 OTHER (PLEASE SPECIFY BELOW)

What will constitute passing this elective? (i.e., B on a paper, exam score of 75% etc..)

SUMMARY OF DAILY ACTIVITIES: (Brief Outline)

	MON	TUES	WED	THUR	FRI	SAT/SUN
A.M.						
NOON						
P.M.						

Are you related to the student requesting this elective? Yes No Relationship: _____
 If yes, please indicate a co-evaluator: _____

Please attach credentials information as outlined on the front of this form for co-evaluator

SUPERVISOR'S SIGNATURE: _____ DATE: _____