

PERMISSION TO TAKE OFF-CAMPUS ELECTIVES

Please complete using fillable form (or if completing by hand, please print):

Name: _____ Date: _____

Name of Host Institution: _____

Course Title/Specialty: _____

Signature Approval Required by GW School of Medicine and Health Sciences Course Director:

Course Director's Signature – Required

Dates of Course: From _____ to _____

Preceptor or Contact Name: _____

Preceptor or Contact Number: _____

How is this course listed on your schedule: _____
(i.e. med390; med 391; surg390; ped391, etc.)

Does this fulfill a requirement? _____ Which requirement? _____

How can we reach you while you're away:

Email address: _____

Please check your email on a regular basis. All class messages will be sent via email.

Cell phone number: _____ Home phone voice message: _____

Note:

When this information is completed, signed and received by the Dean's Office prior to the beginning date of the elective, credit will be registered and GW malpractice insurance will be in effect.