



Virginia Commonwealth University

VIRGINIA COMMONWEALTH UNIVERSITY
SCHOOL OF MEDICINE

APPLICATION FOR EXTRAMURAL COURSE OR CLERKSHIP
TO BE COMPLETED BY STUDENT
(It is the student's responsibility to be certain that the Electives Office
receives this form for completion and mailing.)

Name: _____

Mailing Address: _____

Currently enrolled as : [] 3rd year student [] 4th year student.

Specific Course or Clerkship for
which application is made: _____

Exclusive Dates of Clerkship: _____

Preceptor of Clerkship: _____

Preceptors's Address: _____

APPROVAL

The medical student named above is in good standing at this institution. He/She will pay tuition at our school during
the period indicated. Malpractice insurance covers the student away from our school. He/She is approved to take
the requested clerkship for credit. At the conclusion of the rotation an evaluation will be required.

Signature: _____ Date: _____
(Assoc. Dean of Student Activities & Electives)

ACTION

To be completed by Preceptor (or comparable official) of where the above student is seeking to take clerkship.

[] Student has been accepted into the above clerkship and will report to: _____

[] Student has been rejected from above clerkship.

Name, Title and Address of Preceptor: _____ Signature: _____
_____ Date: _____
