



MOUNT SINAI
SCHOOL OF
MEDICINE

Office of the Registrar
One Gustave L. Levy Place
Annenberg Building-Room 5-16
Box 1257
New York, NY 10029-6574

Phone 212.241.6691
Facsimile 212.369.6013
E-mail: registrar@mssm.edu

Tailor-Made Research Elective Proposal & Registration

Name _____ Date _____

Life# _____ Phone: _____ Class of: _____

Project Title _____

Dates: ____/____/____ to ____/____/____ Hours per week _____

Total per week _____

Weeks of elective requested: _____

- I am requesting more than 4 weeks credit for research elective. I have received prior approval from Dr. Zier.
- Pre-Clinical Research Elective (1st/2nd year)
Expected number of hours credit _____ (30 hours with one semester required in years one or two)
- Clinical Research Elective (3rd/4th year)
Expected number of hours credit _____ (40 hours are required for 1 week of credit)
- Basic Science Research
- Patient-Oriented/Translational/Clinical Research

Instructions

Please write a brief summary of 100-200 words, describing the project you will be working on. Prepare this together with your mentor. The abstract should include a concise, descriptive title, your name and your mentor's name, department in which you will be working, and text describing the elective. Use first names and last names for you and your mentor. **Be specific about what your role will be if this is a project that several people are involved in, or if you have worked on the project before. If this is a new elective, describe how you plan to use your time.**

Previous Work on this Project

If you have previously worked on this project or one highly related, please indicate below the dates and whether it was for elective credit, during the summer, or during a year of special matriculation.

<u>Dates</u>	<u>Elective</u>	<u>Special Matriculation</u>
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Registrar Office Use Only:

Code: _____ Course ID: _____ Processed: ____/____/____

Instructor/Preceptor: I have accepted this student for an elective under my supervision. I will ensure that the student has a well-defined curriculum that supports the goals & objectives. For clinical electives, I understand that the student must spend at least 40 hours per week under supervision in order to receive one week of credit. I agree to submit an evaluation of the student's work at the completion of the elective experience to **the Office of the Registrar, Box 1257, Mount Sinai School of Medicine, One Gustave L. Levy Place, New York, New York 10029.**

Signature _____ Date _____

Name _____ Phone _____

MSSM Affiliated Hospital & Dept. _____ N/A

Address _____

If instructor is not affiliated with MSSM, corresponding Clerkship Director, Department Chair of MSSM sponsor: I support the planned elective. If there are any questions regarding the evaluation submitted, I agree to be available to review the evaluation.

Signature _____ Date _____

Name _____

Department _____ Phone _____

Student: I will not be under the direct supervision of any family members or individuals with whom I have a personal relationship. I understand that to earn elective credit I must apply in advance of carrying out the elective.

I have written the attached project description in my own words

Signature _____ Date: _____

Associate Dean: Proposed Tailor-Made Research Elective has my final approval.

Student is approved for more than 4 weeks of credit.

Signature _____ Date: _____