Away-Domestic Elective Request Form

This PDF form must be completed and attached to the "Student Scheduling Request" four weeks prior to start date of the elective receive appropriate credit. This will ensure the distribution of student assessment forms, clinical compliance audits, and hospital site assignments are processed in a timely manner. Incomplete forms will delay processing. Please note that students cannot receive credit for an elective if they are also being paid.

Please check the box next to the type of away rotation you are requesting to schedule:

☐ **Away-Domestic Elective at Another Medical School**

a. An elective offered at another U.S. medical school or site. Use VSLO (https://vslo.aamc.org/vslo) if applying to an LCME VSLO host institution.

☐ I would like to submit a request for this elective to count as a "Patient Facing" elective.

a. Elective must be an in-person clinical elective at an LCME VSLO host institution
b. Student must provide official catalog description for elective.
   i. URL for catalog description:

☐ I would like to submit a request for this elective to count as my "Acute Care" requirement.

1. Elective must be a clinical EM or Critical Care elective at an LCME VSLO host institution.
   a. Four weeks in length and in-person.
2. Student must provide official catalog description for elective.
   a. URL for catalog description:

☐ **Away-Domestic Catalog Sub-Internship***

**No away sub-internships will be approved after 03/31/2025*

a. An External Sub I in Medicine,Pediatrics, Ob/Gyn, Surgery and Family Medicine that has already been approved as a sub-internship at an LCME accredited school, may be submitted for review and approval to insure that it meets the guidelines.
   i. As a general rule, "Sub-Internship" must appear in the title and description of the elective in order to be approved.
b. The Sub-Internship Inter-Institution Equivalency Questionnaire must be completed by the host institution prior to scheduling the rotation and submitting with initial scheduling request.
   i. URL for catalog description:

PLEASE COMPLETE THE INFORMATION BELOW AND SUBMIT A STUDENT SCHEDULING REQUEST FORM

Name: UIN#:

Cell Phone#: Email: Graduation Class:

Elective Title*: **Elective title in COM database may vary.*

Supervising Physician or Program Director/Coordinator (Print name):

Email address evaluation form to be sent to: Phone Number:

Clinical Site: City: State:

Please note - 40 clinical/contact hours is the equivalent of one week of elective credit.

*Start Date: End Date: Total Weeks Credit: Hours per Week:

**Important Note:* *Students cannot schedule an away elective during UIC's winter break.*

Is an Agreement for Student Placement in a Practice Setting required?
(If so, please allow up to three months to process. The site coordinator/director should contact Janet Comins (jcomins@uic.edu) in Educational Affairs.)

Clinical Supervisor's Signature*: _____

**A signature is not required if you are providing an official acceptance email from the program.*