DEPARTMENT OF ORTHOPAEDIC SURGERY CONFIRMATION OF AWAY ELECTIVE

STUDENT NAME: ROCKET ID#:

PHONE: PAGER:

UT EMAIL:

NOTIFICATION OF ACCEPTANCE FROM HOST INSTITUTION IS ATTACHED: ☐ Yes ☐ No

UT HSC OFFICE OF THE REGISTRAR HAS BEEN NOTIFIED OF ACCEPTANCE: ☐ Yes ☐ No

TITLE OF ELECTIVE THAT HAS BEEN ACCEPTED:

ELECTIVE TYPE: CLINICAL ☐ NON-CLINICAL ☐

UT COURSE #: **ORTH750 (4-week)**

UT CRN #: VSAS COURSE #: TERM:

CONFIRMED DATES FOR ELECTIVE:

SITE/HOSPITAL/INSTITUTION & LOCATION:

FACULTY SUPERVISOR:

***** ATTACH A READABLE COPY OF THE COURSE DESCRIPTION TO YOUR FAX OR EMAIL******

CONTACT INFORMATION FOR AWAY ELECTIVE COORDINATOR:

NAME:

TITLE:

PHONE:

EMAIL: FAX:

Return this form to Tracy.Jahns@utoledo.edu & hscregistrar@utoledo.edu

Failure to do so will jeopardize the ability of the student to receive credit for the rotation; this will be strictly enforced.