

Proposed Individually Arranged Elective/Research

Student Name:		UMID:	Graduation Year:	
Branch (if applicable):		Is this experience part of your Capstone for Impact Project: Yes No		
Dates: Period: Duration:		Type of expe	-	
Dates: Period: Duration:		Type of expe	mence.	
Department:		Hospital:		
2 op a. v		1100pitali		
Responsible Faculty Member:		Faculty Member's Signature:		
		James U. Partular		
Responsible Faculty Member's (Contact Info:	×		
	Estimated Distribut	tion of Student	's Time	
Percentage (must equal 100% in 5% increments)	Category		Description	
	Outpatient Clinical Care		Clinical Care is categorized as to where the patient is, not the student (i.e. in radiology if a student is reading films on inpatients, then choose "inpatient clinical care."	
	Inpatient Clinical Care			
	Emergency Department Clinic	al Care		
	Service Learning		Service learning is experiential education where students apply their learning to community problems, while reflecting on their experience. Please include patient care portions of service learning in the clinical care categories above.	
	Conference/Lectures/Seminar	´S		
	Basic Science Research			
	Simulation		Includes simulation center & standardized patient experiences.	
	Clinical Research			
	Independent Study			
	Other (please be specific)			
100%	MUST TOTAL 100%			
Average number of patients the s On-call responsibility occurs ever Where and when to report first d	y day(s)			
To enhance knowledge and skan interviewing, physical interpretation of data clinical judgment procedures (please specific procedures proc	cills pertaining to: examination and other patient in	nteractions		

_ therapy and advice to patients

tudent will be evaluated on each of the following: (please check those that apply)	
quality of care given (including clinical judgment)	
the number of patients given care	
participation and performance in conferences	
level of knowledge (including new knowledge)	
level of skills	
other (please specify)	
Methods to be used in student evaluation include: (please check those that apply)	
observation of performance by faculty	
observation of performance by house officers	
assessment of write-ups/reports	
written/oral tests	
other structured skills testing	
other (please specify)	
Description of experience: (attach separate sheet if needed)	
UMMS CLERKSHIP DIRECTOR MUST COMPLETE	
ection to be completed by Departmental Clerkship Director	
By signing this form I approve this elective for ng amount of credit from the University of Michigan Medical	
chool. Clerkship Directors must check <u>one</u> of the three spaces below (meets clinical, non-clinical, or research credit).	
clinical (50% or > patient care)non-clinical (< 50% patient care) research only credit	
CLERKSHIP DIRECTORS – PLEASE CHECK TYPE OF CREDIT ABOVE BEFORE RETURNING THIS FORM	
indorsed by (print Clerkship Directors name):	
indoised by (print elerkship birectors hame).	
Clerkship Director's Signature:Date:	
Please return to:	
cheduling Team	
Office of Medical Student Education	
CACT I U DIC' D'IL	
310 Taubman Health Sciences Building	
mail: clinicalscheduling@umich.edu	
mail: clinicalscheduling@umich.edu ax: 734-936-3510	
mail: clinicalscheduling@umich.edu	
mail: clinicalscheduling@umich.edu fax: 734-936-3510 FOR OMSE USE ONLY	
mail: clinicalscheduling@umich.edu	