

Proposed Individually Arranged Elective/Research

Student Name:		UMID:	
otadent italiie.		O.V.II.D.	
Branch (if applicable):		Is this experience part of your Capstone for Impact Project: Yes No	
Dates:	Duration:	Type of exper	rience:
Department:		Hospital:	
Responsible Faculty Member:		Faculty Member's Signature:	
Responsible Faculty Member's C	Contact Info:		
	Estimated Distribution	on of Student's	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 Clinica	l 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/Seminars		
	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 some control of patients the some control of patients the some control of t	y day(s) ay of course/clerkship: ease check those that apply) cills pertaining to: examination and other patient int	eractions	
therapy and advice to	patients		

Student 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 CO	OMPLETE
Section to be completed by Departmental Clerkship Director	
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	from the University of Michigan Medical
By signing this form I approve this elective for ng amount of credit School. Clerkship Directors must check one of the three spaces below (meets clinical school).	
	l, non-clinical, or research credit).
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