

Name: _____

University of Nevada School of Medicine
2009 - 2010 Elective Schedule

Date Received _____

The following schedule must be returned to the OFFICE OF MEDICAL EDUCATION **NO LATER THAN MAY 15, 2009**

OFFICE USE ONLY

Student's Name: _____

RURAL (4) _____

Address: _____ Zip: _____

OUT-OF-STATE (max 12) _____

Phone No.: (____) _____ E-mail: _____ Pager or Cell: _____

IN-STATE _____

TOTAL CREDITS (36) _____

TIME PERIOD	CREDITS (1WK = 1CR)	ELECTIVE TITLE COURSE NO. & SECTION (i.e.,SURG661M.001)	ELECTIVE LOCATION	INSTRUCTOR'S NAME	DEPARTMENT APPROVAL: Signature of electives coordinator or department assistant
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EXAMPLE:					
FROM: 6-21-09		TITLE: PLASTIC SURGERY	RENO	GARETH STRAND, M.D.	_____
		COURSE # SURG 661M		Preceptor	Electives Coordinator
TO: 7-16-09	4	SECTION# 001 (RENO)			_____
					Dept. Assistant

FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

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FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

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FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____
FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____
FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____
FROM: _____		TITLE: _____	_____	_____	_____
		COURSE # _____	_____		
TO: _____		SECTION# _____			_____

All schedule changes must be requested in advance and require prior approval from the department **AND** the Associate Dean for Medical Education, Office of Medical Education. Students are responsible for filing a "Request to Change Elective Assignment" form with the Office of Medical Education. **Allow at least two weeks for processing.**

Student Signature

Career Advisor

Associate Dean for Medical Education

NO CHANGES IN THE ELECTIVE SCHEDULE WILL BE ALLOWED AFTER DECEMBER 1, 2009