NEW ELECTIVE COURSE DESCRIPTION

University of Missouri-Kansas City School of Medicine
Council on Curriculum, MG-200
2411 Holmes Street, Kansas City, MO 64108
Phone: (816) 235-1852

This form must be filled out by the student and received by the Curriculum Office ***by the first calendar day of the block prior to the elective****. Failure to do so may result in a "not for credit" medicine elective block or denial of request. Evaluator email must be provided.*

ELECTIVE AND CONTACT INFORMATION

Student Name: ______________ Block /Year of Elective: ______________

Med Year: ______ Unit: ______ Student ID: ______

Elective Title: ______________

Institution Name: ______________

Address: ______________

City: ______ State: ______ Zip: ______ Country: ______

Contact Person: ______________

Phone: ______________ Email: ______________

Evaluator Name: ______________

Phone: ______________ Email: ______________

Duration of Elective: ☐ 4 week Block ☐ Other (explain):

Proposed Elective Category (select only one):

☐ Community/Family Medicine ☐ OB/GYN ☐ Radiology ☐ Miscellaneous
☐ Internal Medicine ☐ Pathology ☐ Research
☐ Neurology/Psychology ☐ Pediatrics ☐ Surgery

Is this elective a Sub-Internship?: ☐ Yes ☐ No *If yes, objectives MUST reflect duties of a sub-intern

Please indicate instructor level of evaluator: ☐ Faculty Member ☐ Physician ☐ Scientist Researcher
(residents cannot be the primary evaluator for students)

Is the evaluator related to the student requesting this elective? : ☐ Yes ☐ No
If yes, please indicate the relationship : ______________
and specify an alternate evaluator: ______________

☐ All information contained in this form has been verified with the elective program prior to submission to the Council on Curriculum by the student requesting the elective.

Student Signature: ______________ Date: ______
ETC Signature: ______________ Date: ______

For Curriculum Office Use Only

Approval: ______________ Date: ______
Chair of Curriculum

Elective Title: ______________

Course #: FileMaker #:

☐ Credit	☐ Audit / Reason:

CURRICULUM INFORMATION

UMKC Competencies: (Select which competencies are addressed in this elective.)

- ☐ Interpersonal and Communication Skills
- ☐ Medical Knowledge
- ☐ Practice-Based Learning and Improvement
- ☐ Interpersonal Collaboration
- ☐ Systems-Based Practice
- ☐ Patient Care
- ☐ Professionalism
- ☐ Personal and Professional Development

Educational Objectives: (Describe the facts, concepts, and skills the student is expected to know upon completion of the elective.)

1.
2.
3.
4.
5.
6.

Schedule Information:

____
____
____

Elective Primarily Based: ☐ Institution ☐ Office ☐ Hospital

Maximum Number of Students (if applicable):

Dates Elective is Offered:

Year Level Accepted for this Elective (MS-3 is equivalent to traditional MS-1 and so on):
☐ MS-3 ☐ MS-4 ☐ MS-5 ☐ MS-6

Call: ☐ Yes ☐ No If Yes, Frequency:

Prerequisites: ☐ Yes ☐ No If Yes, List:

To meet requirements for one block of elective credit, the student must participate in a **minimum of 160** hours of education activities. To be classified as a **clinical** elective, the student must spend 50% **(or at least 80 hours)** in clinical activities.

TEACHING METHODS: (Specify number of **<u>hours per block</u>** for each)

______ Outpatient Visits (Clinical)
______ Hospital/Rounds/Patient Care (Clinical)
______ Operating Room (Clinical)
______ Laboratory
______ Lecture /Conference
______ Reading/Self-Directed Learning
______ Research
______ Other (*Please Specify Below*)
____
____

EVALUATION METHODS: (Check all that apply)

- ☐ Clinical performance
- ☐ Reading assignments
- ☐ Oral presentations
- ☐ Examinations
- ☐ Other (*please specify below)*

____
____

GRADING CRITERIA: (Please select the grading scale/metrics you will be utilizing.)

☐ Pass/ Fail ☐ Honors/High Pass/Sat. Pass/Marg. Pass/Fail

Note: Research electives cannot be Pass/Fail