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 **before 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's institutional email must be provided.*

ELECTIVE AND CONTACT INFORMATION

Student Name: _____ Block /Year of Elective: _____
Med Year: _____ Unit: _____ Student ID: _____
Elective/Research Project Title: _____
Institution Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Country: _____
Evaluator Name: _____
Phone: _____ Email: _____
Contact person: _____
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/Psychiatry ☐ Pediatrics ☐ Surgery

Is this elective a Sub-Internship?: ☐ Yes* ☐ No
**If yes, educational objectives must reflect duties of a sub-intern, and the student must submit documentation from the institution or evaluator verifying the elective's classification at the sub-internship level.*

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: _____

☐ I have read and understand the Council on Curriculum elective policies.
☐ 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 must submit confirmation of the elective from the elective evaluator, program, or institution.*

Student Signature: _____ Date: _____
ETC Signature: _____ Date: _____

For Curriculum Office Use Only

Approved: ____ Denied: ____ By: _____ Date: _____
Associate Dean for Clinical Medical Education

Elective Title:

Course #: FileMaker #:

☐ Credit ☐ Audit / Reason:

CURRICULUM 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:

Schedule Information:

_____

_____

_____

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.

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

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 **hours per block** 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: All research and clinical electives will utilize the clinical grading scale.

Honors | High Pass | Sat. Pass | Marg. Pass | Fail