NYU Grossman School of Medicine

APPLICATION FOR RESEARCH ELECTIVE CREDIT

APPLICATION INSTRUCTIONS

1. Complete all the required information in Sections 1 and 2 of the application.
2. Provide a full description of the research project. The description should encompass the relevant details of the project, be no less than two or three paragraphs in length and clearly state your role in the project.
3. The application must be signed by the supervising preceptor.
4. Return the completed application no less than **two weeks** prior to the beginning date of the project. Applications submitted after that will not be accepted.
5. Applications submitted with insufficient data will be returned to the student.
6. **Class of 2025:** In addition to your 12-week Scholarly Concentration, you may request a maximum of 12 weeks of research elective credit out of your required 26 weeks of total elective credit. Note, the minimum number of weeks needed to complete the Honors Program is 20 weeks (12 weeks of concentration plus 8 weeks of elective time).
7. **Class of 2026:** In addition to your 12-week Area of Concentration, you may request a maximum of 12 weeks of research elective credit out of your required 32 weeks of elective credit. Note, the minimum number of weeks needed to complete the Honors Program is 20 weeks (12-week Area of Concentration plus 8 weeks of the Summer Research Opportunity **OR** 12 weeks of concentration plus 8 weeks of elective time).
8. **Class of 2027:** In addition to your 8-week Area of Concentration, you may request a maximum of 12 weeks of research elective credit out of your required 24 weeks of total elective credit. Please note that Honors can only be applied for students pursuing a 4-year research or dual degree year.

APPLICATION CONTINUES

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SECTION 1 (To be completed by the student)

Name: _____ Class: _____

Address: _____ Cell Phone: _____

Project Title: _____

Department: _____

Project Description:

Research Dates: From _____ (mm/dd/yyyy) To _____ (mm/dd/yyyy)

Number of weeks elective credit requested: _____

Student's Signature: _____ Date: _____ (mm/dd/yyyy)

APPLICATION CONTINUES

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SECTION 2 (To be completed by the preceptor)

Title: _____ Name: _____
First Last

Department: _____

Telephone: _____ Email: _____

Location: _____ Address: _____
(In-House Location / Building) (Hospital / Medical School Address)

I agree to supervise this student in the performance of the research elective described above, including the design, execution and report of the project.

Preceptor's Signature: _____ Date: _____
(mm/dd/yyyy)

OFFICE USE ONLY

Approved: ○ Yes ○ No Number of weeks elective credit: _____

Comments:

Signature: _____ Date: _____
Senior Associate Dean for Medical Education (mm/dd/yyyy)

PLEASE SUBMIT BY EMAIL, FAX OR IN-PERSON TO THE INFORMATION PROVIDED BELOW

Registration & Student Records 550 1st Avenue, Medical Science Building, Suite G90, NY, NY 10016 Tel: (212) 263-5291 Fax: (212) 263-5264 E: Janet.Montero@nyulangone.org