APPLICATION FOR SERVICE LEARNING ELECTIVE

NOTE: Deadline for submission is two weeks prior to the elective beginning date in order to receive elective credit. Forms submitted after that date will not be eligible for credit. Please see the course description for specifics regarding hourly and curricular requirements for elective credit.

GENERAL INFORMATION TO BE COMPLETED BY THE STUDENT

NAME: ______________________________________ CLASS ______________

ADDRESS: ________________________________ TELEPHONE: ______________

Please indicate the curriculum timeline you plan to follow by marking a check in the left column:

| Longitudinal Elective (1-6 months - 2 weeks of credit) | 2 Week Elective | 4 Week Elective |

EXACT DATES OF ELECTIVE: __________________________________________________

Please list up to 3 service projects that you are considering taking part in during this elective time (you will be required to complete at least 50% of your hours in one project):

1. __________________________________________________
2. __________________________________________________
3. __________________________________________________

STUDENT SIGNATURE: __________________________ DATE: ______________

INFORMATION TO BE COMPLETED BY THE PRECEPTOR

NAME: Linda Tewksbury, MD TELEPHONE: 212-263-6088

TITLE: Associate Dean for Student Affairs

Office Address: 550 First Avenue, MS G-55

STUDENT’S RESPONSIBILITIES

Will there be patient contact? __________________________ If yes estimate hours spent in:

Private practice office hours: ________________ Emergency Room: ______________

Hospitalized patients: __________________________ Outpatient clinics: ______________

Other, please specify: __________________________

Total hours per week the student will spend on this elective: ____________

6.17.20
Description of student’s daily activities:
Students will participate in 30 hours of community service per week of elective credit, and complete an introductory didactic module along with various preparation and reflection activities throughout their involvement in this elective.

I agree to supervise the student above and evaluate for completion of course requirements at the conclusion of this elective.

Preceptor’s signature/academic title

Approved: _____yes _____ no  Number of weeks elective: __________

Senior Associate Dean for Medical Education    date

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