



Return completed form and documents to:

Office of Student Affairs
UIC College of Medicine (MC 785)
1853 West Polk Street Room 112 CMW
Chicago, Illinois 60612
312-996-2450 Fax: 312-413-3787

M4 SCHEDULING FORM

Scheduling requests must be submitted 4 weeks prior to the start of the elective
This form will not be processed without all necessary documents and signatures
After approval of scheduling you must also REGISTER
by UIC Web for Student / Student Self-Service

1. Student Name: _____ UIN #: _____ Class of: _____
 Cell phone Number: _____ Home Number: _____ Email: _____
2. Formal Experience Title: _____ Program Number from UIC catalog: _____

3. ACTION: <input type="checkbox"/> Schedule Rotation <input type="checkbox"/> Change dates <input type="checkbox"/> Cancel Rotation	4. CLINICAL SITE: <input type="checkbox"/> Christ <input type="checkbox"/> Cook County <input type="checkbox"/> II Masonic <input type="checkbox"/> Lutheran Gen. <input type="checkbox"/> Mercy <input type="checkbox"/> Reese <input type="checkbox"/> St. Francis <input type="checkbox"/> St. Joseph <input type="checkbox"/> UIH <input type="checkbox"/> WSVA <input type="checkbox"/> Other _____	5. DATES OF ROTATION Start: ____/____/____ Monday END : ____/____/____ Saturday Total weeks credit: ____	6. M3 Requirements completed? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, the following procedure must be followed: a. Must meet with OSA Advisor. b. Follow scheduling procedures as described below. c. Return completed forms to M4 Coordinator for approval by the Associate Dean for Curriculum.
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7. APPROVED EXPERIENCE AS PUBLISHED IN THE UIC COM CLINICAL EXPERIENCES CATALOG

UIC Program Director: _____ Signature: _____ Date: _____

8. ELECTIVE OFFERED BY ANOTHER LCME ACCREDITED MEDICAL SCHOOL:

- a. A complete description of the experience including objectives to be met (copy from catalog if possible).
- b. A Letter of Acceptance from the Medical School for the specific rotation dates indicated above and indicating the elective coordinator (person who has agreed to supervise and evaluate you on this experience).
- c. Signature of the Director of Predoctoral Education on the M4 Scheduling Form and on the elective description.
- d. **Name and address** where evaluation form should be sent is required (complete # 10 below).
- e. If other medical school is not LCME approved, e.g., a foreign medical school, then you must include:
 - (1) A complete description of the experience including purpose, activities, objectives, duration, schedule, location, supervising faculty member and his/her contact information, and mechanism for assessment.
 - (2) Include a description of the medical school.

Director of Predoctoral Education _____ Signature: _____ Date: _____

9. SELF-DESIGNED ELECTIVE OR VARIATION OF A DESCRIBED ELECTIVE:

- a. A complete description of the experience including purpose, activities, objectives, duration, schedule, location, supervising faculty member, and mechanism for assessment. (Use the elective descriptions in the *UIC COM Clinical Experiences Catalog* as a guide for your description). If this is a variation of a UIC elective also indicate the reason you are requesting the variation.
- b. Signatures of the Program Director and the Director of Predoctoral Education are required on the M4 Scheduling Form and on the elective description.
- c. Further approval and forms may be required by the Education Dean.
- d. **Name and address** where evaluation form should be sent is required (complete # 10 below).

Supervising Faculty Name: _____ Signature: _____ Date: _____

Director of Predoctoral Education: _____ Signature: _____ Date: _____

10. SEND EVALUATION FORM TO (please type or print legibly):

Supervising Faculty Name/Coordinator/Contact Person: _____

Address: _____ Phone/FAX #: _____

City/State/Zip: _____ Email: _____

11. RESEARCH ELECTIVE: Student must meet with the M4 Academic Advisor to complete additional paperwork.

FOR OFFICE USE ONLY:

Education Dean: Name: _____ Signature: _____ Date: _____

Director, ISP Program: Name: _____ Signature: _____ Date: _____

WHITE - Student Affairs YELLOW - UGME PINK - Program Director GOLD - Student Data Entry by: _____ Date: _____