College of Medicine and Life Sciences MD Program

PRECLINICAL ELECTIVE REQUEST FORM

Office of the Registrar
0 D L Q Campu V
5 R F N H W + D O O 5 R R P
Mail Stop
Toledo, OH 4
Phone: 419.
Fax: 419. 4
HSCregistrar@utoledo.edu

Year ____ Term __

10 = Spring
30 = Summer
40 = Fall

Please indicate which year in the program you are enrolled:

…Year 1 Medical Student

…Year 2 Medical Student

Rocket ID: R ______________________ Phone: ______________________

Student Name: ____
Last Name, First MI

Student Email: ______________________ @rockets.utoledo.edu

Student Instructions

8VH WKLV IRUP WR PDNH [illegible]
SUH FOLQLFDO HOHFWLYH DIWHU WKH DGG GURS SHULRG HQGV UHTXLUHV WK
VXEPLWWHG EHIRUH WKH SUH FOLQLFDO HOHFWLYH LV FRPSOHWH

Further information on preclinical electives in the College of Medicine and Life Sciences MD Program can be found at:

Requested Preclinical Elective

Subject Code	Course Number	Course Title
([DPSOH 6201		&RPPXQLW\ +HDOWK ,VVXHV

All the requirements have been completed for the above elective, and I am requesting that this preclinical elective be recorded on my academic record.

______________________________________ Date: ______________
Student Signature

DirectorA209.340r0tstdinato

______________________________________ Date: ______________
Director/Coordinator Signature

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Department

Please return completed form to the
H H D [illegible] S X V Office of the Registrar
+ 6 & 5 H J L V W U D U # X W R O H G R H G X