COLLEGE OF MEDICINE
RESEARCH ELECTIVE APPLICATION

Student Name: _____ **Student Email (UT):** _____

UT Faculty Name: _____ **Faculty Email:** _____

Campus: ☐ Memphis ☐ Knoxville ☐ Chattanooga ☐ Nashville

Length of Elective: ☐ 2 weeks ☐ 4 weeks

Block: _____ **Start Date:** _____ **End Date:** _____

Academic Department/Division: _____ **Research Site:** _____

IRB Approval (if working with human subjects): ☐ **Yes** ☐ **No**

Project Description/Target Population:

Project Objective:

Student Signature: _____ **Date:** _____

Faculty Signature: _____ **Date:** _____

SEND COMPELTED FORM TO: jmcadoo3@uthsc.edu and kbettin@uthsc.edu for approval.

For Office of Medical Education Use Only

UT Faculty status verified by Signature: _____ **Received by Date:** _____

Approved by Signature: _____