DARTMOUTH MEDICAL SCHOOL
Elective and Subinternship Application
(This form is to be used for year 3/4 electives and year 4 subinternships only)

*****Deadline*** In order to receive credit for electives/subinternships and to be covered for liability insurance, paperwork must be received in the Registrar's Office 4 weeks before the start of the course. No credit will be awarded for electives/subinternships taken prior to submission of this form.**

Directions:
1). Students should fill in Section 1 completely.
2). Submit the form to the Registrar's Office (4th floor Rubin, HB 7090) for processing.
3). Registrar's Office will forward to Sponsor for approval and completion of Section 3.
4). Students will receive the pink copy of the form once it has been approved.

SECTION 1

Student Name:_____ DMS Year:_____Graduation Year:_____

Dates of Elective: From:_____To:_____ Number of Weeks:_____

Title of Elective: _____ Number of Credits:_____

Elective Department/Number:_____
(Example: **"MEDI 525"** - Leave blank if this is an away or non-established elective/subinternship)

Elective Type (check all that apply): ☐ Clinical ☐ Research/Reading ☐ Full-time ☐ Part-time

Faculty Sponsor: _____

Department & Coordinator: _____

Institution & Hospital: _____

Mailing Address: _____

_____

SECTION 2

The medical student named above is in good standing at Dartmouth Medical School (DMS). He/She will pay tuition at DMS during the period indicated and is covered by liability and personal health insurance while away from DMS. An evaluation report is required and will be mailed to the address indicated below with a completed copy of this form.

_____ _____
Signature of Dartmouth Medical School Registrar Date

SECTION 3 (To Be Completed By School/Hospital Where Student Is Seeking Elective)

Student will be expected to report to:

Name:_____

Location:_____

Date:_____ Time:_____

_____
Signature of Approval Date

Evaluation to be mailed to:

Name:_____

Email Address:_____

Mailing or Box Address:_____

_____

_____

Telephone: (_____)_____

***Please send completed Application (with all copies) to:**

DMS Registrar's Office - 7090
1 Medical Center Drive
Lebanon, NH 03756