MICHIGAN STATE UNIVERSITY COLLEGE OF HUMAN MEDICINE
Upper Peninsula Campus
418 W. Magnetic Street, Marquette, MI 49855
Phone (906) 228-7970 Fax (906) 228-5734

ELECTIVE REQUEST

(Please print or type)

Student Name:_____
First **Middle** **Last**

Type of Elective: _____ **Preferred Dates:** _____

Student Mailing Address: _____

Phone: _____ **Fax:** _____ **Email Address:** _____

What are your ties to the U.P.? _____

_____

What are your housing arrangements for this elective? _____

Social Security #: _____ **Sex:** _____ **Place of Birth:** _____ **Citizenship:** _____

EDUCATIONAL BACKGROUND:

Medical: Medical College: _____

Expected Date of Graduation: _____ Degree: _____

Premedical: College or University: _____

Expected Date of Graduation: _____ Degree: _____

Step I score _____ # of attempts _____ CSA exam taken and passed? Yes _____ No _____
Step II score _____ # of attempts _____ Comlex I score _____ # of attempts _____
Step III score _____ # of attempts _____ Comlex II score _____ # of attempts _____
If you are an International Medical Graduate are you ECFMG certified: Yes _____ No _____

Describe any special areas of interest you would like to pursue during this elective:

_____

_____

What specialty(ies) are you presently considering? _____

_____

If Family Practice, are you considering interviewing for a position in the Marquette Family Practice Residency program? Yes ☐ No ☐

SIGNATURE: _____ **DATE:** _____

FOR HOSTING SITE USE:

☐ Elective approved for the dates _____.

☐ Elective not approved. Comments: _____

_____ _____
Signature of Authorized Official **Date**

Revised 7/27/04