RURAL MEDICINE ELECTIVE
Wayne State University School of Medicine
Request Form

PERSONAL INFORMATION

Student Name:

Mailing Address:

Phone: **Email Address:**

Preferred Location: **Preferred Dates:**

What are your ties to the Upper Peninsula?

Gender: **Place of Birth:** **Citizenship:**

EDUCATIONAL BACKGROUND

Medical:

Medical School

Expected Date of Graduation: **Degree:**

Pre-Medical:

College or University

Date of Graduation **Degree:**

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

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:**

(please enter WSU-SOM student # if submitting electronically)

For Hosting Site Use:
Elective approved for the following dates
Elective not approved. Comments

_____ _____

Signature of Authorized Official **Date**

Return this form to Lisa Blackwell 101 E. Alexandrine 2nd floor. or via email lblackwe@med.wayne.edu