SCHOOL OF MEDICINE
OFFICE OF MEDICAL STUDENT AFFAIRS

COURSE ADD REQUEST – RESEARCH ELECTIVE

Student Name: _____ ID#: _____

Class of: _____ Today's Date: _____

Circle One: 901 902 903
Course Number: CLNS: _____ Course Dates: _____ to _____
Agreed upon expectations and/or goals for evaluation (please summarize): asdfasdfsa
Student Signature: _____ Date: _____ Research Mentor Name: _____ Date: _____ Research Mentor Signature: _____

For OMSA use only: CRN: _____ *DB:* _____ *INB:* _____