Albert Einstein College of Medicine

Office of the Registrar
Phone: 718.430.2102
Einstein-MDregistrar@einsteinmed.edu

Custom Clinical Elective Registration Form (MD)

Final approval for a Custom Clinical Elective will be granted only upon submission of a completed form, which must include both a description of the clinical experience and the clinician's signature.

Name: _____ Banner ID: _____ Date: _____
Last First

To be completed by student:

Elective Title: _____

Please include a specific project title (maximum 30 characters) that accurately reflects your work. This title will appear on your final transcript. There is no maximum limit on the number of clinical electives a student may take.

Starting Date: _____ **Ending Date:** _____

Elective Description (REQUIRED):
Please describe your project, including your timeline, communication plan with your mentor, and learning goals.

Student's Signature: _____

To be completed by Einstein Faculty Mentor:

I confirm that I have agreed to oversee the Elective as described above. I have accepted the student under my supervision and will ensure that they have a well-defined curriculum that aligns with and supports the stated goals and learning objectives of the elective.

The student and I have established appropriate times and modes of communication to facilitate consistent guidance throughout the elective experience. I also agree to submit the *Evaluation of Clinical Performance & Professional Attributes* form to the Office of the Registrar within four (4) weeks of the elective's completion.

Name: _____

Email: _____ Phone Number:_____

Faculty Signature: _____ Date: _____

PLEASE RETURN THE COMPLETED FORM TO Einstein-MDRegistrar@einsteinmed.edu.

Office Use Only: Block:☐ CRN# ☐