



University of South Alabama – College of Medicine
M4 AUDITION ELECTIVE APPROVAL FORM

*** This form MUST be completed in all sections to be valid ***

Date: ___/___/___ Type of Audition Elective: (SUR, OPD, EMM, OGY, etc.) _____ 400

Student LAST: _____ FIRST: _____ INT _____

Official Name of Institution: _____

Course Title: _____

Doctor/Course Director's name: _____

Institution Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact name, phone number & email address at institution:

Name: _____ Phone: _____

Email address for contact: _____

EXACT DATES BELOW: (if BLOCKS are split-use both lines below-dates must be Monday-Friday)

Block# ___ Dates ___/___/___ to ___/___/___ = ___ weeks

Block# ___ Dates ___/___/___ to ___/___/___ = ___ weeks

Course Objective: Fill in below or attach the printed course description from institution

Course Description: _____

Student's Signature _____ Date: ___/___/___

The student listed above has permission to take the away course described above. The course will serve as: Student MUST attach any supporting documents before faculty sign off below. (check one box below)

- This course is approved to serve as a Required Specialty
This course is approved to serve as a Required Acting Internship
This course is to serve as a regular Elective M4 Course

Faculty Advisor Signature: _____ Date: ___/___/___

Department Chairman Signature: _____ Date: ___/___/___

Associate Dean Signature: _____ Date: ___/___/___