

M4 AUDITION AWAY APPROVAL FORM

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

Date: _____ M4 Course Dept. for schedule: _____ 400

Student First: _____ Middle: _____ Last: _____

Official Name of Institution: _____

Institution's Course Code & 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 Objectives & Description: *Attach the printed course description from institution and write "see attached" below*

The student listed above has permission to take the away course described above.

The course will serve as: *Student MUST attach all supporting documents before signatures are obtained 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 approved to serve as a Required Basic Science
- This course is to serve as a regular Elective M4 Course

M4 Student's Signature : _____

M4 Faculty Advisor Signature: _____

Associate Dean Med Ed Signature: _____