THE UNIVERSITY OF CHICAGO
PRITZKER SCHOOL OF MEDICINE

Biological Sciences Learning Center
924 East 57th Street, Suite 104
Chicago, IL 60637
pritzker.uchicago.edu

OFF-CAMPUS STUDY APPLICATION

This form must be completed and submitted for approval at least **two weeks prior** to beginning the off-campus rotation in order to receive credit.

Approval of the off-campus rotation and number of credits anticipated will be communicated to you via e-mail prior to the start date of the rotation.

Please return completed forms to:
Jill Kelly
BSLC 104S
jkelly@bsd.uchicago.edu
773.702.0290 (phone)
773.702.2598 (fax)

CONTACT INFORMATION & CHECKLIST

Name:_____

Student ID:_____

UChicago Email:_____

Pager:_____

Cell Phone:_____

Is your elective taking place at a LCME accredited medical school?

Yes ☐ No ☐

*Please note if your elective is taking place at an international location, you must fill out the PSOM International Student Experience Checklist.

- ☐ Off-Campus Rotation Acceptance Letter *(Please Attach)*
- ☐ Official Description of the Rotation from the Outside Institution *(Please Attach)*
- ☐ Signature of Either your Career Advisor or your Faculty Advisor *(Please Attach)*
- ☐ Forward the "Institutional Evaluation Form" to the Person Evaluating your Performance during the Off-Campus Rotation. It May Be Returned to Maureen Okonski via Fax to 773.834.1920 or mokonski@bsd.uchicago.edu

INSTITUTION INFORMATION

Institution Name:_____

Institution Address:_____

City:_____ State:_____ Zip Code:_____ Country:_____

Rotation Director/Supervisor Contact Name:_____

Title:_____ Date of Elective From:_____ To _____

Phone:_____ Email:_____

Course Number to Appear on Your Transcript:

☐	ANCC	32800	Anesthesiology		
☐	EMED	35000	Emergency Medicine		
☐	FMED	50200	Family Medicine		
☐	MEDC	73700	Medicine		
☐	NURL	46200	Neurology		
☐	OBGY	44400	Ob/Gyn		
☐	OPTH	48600	Ophthalmology		
☐	ORTH	40000	Orthopaedics		
☐	PATH	50000	Pathology		
☐	PEDS	32000	Pediatrics		
☐	PSCR	46800	Psychiatry		
☐	RADI	42900	Radiology		
☐	SURG	31200	Surgery		
☐	RCON	42900	Radiation Oncology		

Department or Sub-Specialty

Type of Credit Requested:

- ☐ Sub-Internship
- ☐ Clinical Clerkship
- ☐ Research
- ☐ Other Project

ADVISOR APPROVAL

Career/Faculty Advisor's Name:_____ Signature:_____

Department:_____ Date:_____

STUDENT STATEMENT & CHECKLIST CERTIFICATION

I, _____, certify that the above statements are true and correct.

Signature:_____ Date:_____

If you have any questions, please contact Maureen Okonski (mokonski@bsd.uchicago.edu).

PRITZKER SCHOOL OF MEDICINE OFFICE USE –

Date Received:_____ Date Processed:_____

Units: _____ (*Will Be Assigned by the PSOM*)