



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: Attach the printed course description from institution and write – see attached

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 all supporting documents before faculty to 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 approved to serve as a **Required Basic Science**
- This course is to serve as a regular **Elective M4 Course**

Faculty Advisor Signature: _____ Date: ____/____/____

Department Chairman Signature: _____ Date: ____/____/____

Associate Dean Med Ed Signature: _____ Date: ____/____/____