

OCA: \_\_\_\_\_



**SCHOOL OF MEDICINE**  
**OFFICE OF THE DEAN**

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## DOMESTIC AWAY ELECTIVE FORM

**- Please complete, sign, attach confirmation & return to the SOM Dean's Office -**

<b>Student First Name</b>	<b>MI</b>	<b>Last Name</b>	<b>Email Address</b>
<b>Program/Institution Name</b>			
<b>Title/Description of Elective</b>			
<b>Visiting Student Coordinator/Contact Name</b>	<b>Phone Number</b>	<b>Visiting Student Coordinator/Contact Email Address</b>	
<b>Street Address</b>			
<b>City</b>	<b>State</b>	<b>Zip Code</b>	
<b>Departure Date</b>	<b>Date of Return</b>		

**Students must participate in electives in the state of Oregon or at an approved academic health center.**

I, \_\_\_\_\_, request permission to take the above elective course.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OHSU Approval: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Signature of Department or Dean's Office Official)*

(CRN \_\_\_\_\_)

**\*\*Confirmation from the Away Institution must be attached to this form.**