|  |  |  |
| --- | --- | --- |
|  | **Università Cattolica del Sacro Cuore*****CLINICAL AND RESEARCH ELECTIVES NETWORK*** |  |

**A: PERSONAL INFORMATION**

***To be completed by student. Please print or type:***

|  |
| --- |
| NAME |
| Last  | First | Middle |
| Male [ ] Female [ ] |
| Date of Birth [MM/DD/YEAR]  |
| Citizenship |

**Mailing Address**

|  |
| --- |
| Street  |
| City  |
| State Zip |
| Country |
| Email address |
| Telephone Number |

**PLEASE COMPLETE SECTIONS B AND C, FOR EACH ELECTIVE YOU WOULD LIKE TO APPLY TO**

**B: DETAILS OF PROPOSED ELECTIVES)**

|  |  |
| --- | --- |
| **Host Institution**  | **Elective and/or Research requested: (i.e. General Medicine, Surgery, Paediatrics).**  |
|  |  |

**C: REQUEST FOR ACADEMIC RECOGNITION**

***Please provide details on learning objectives to be accomplished: clinical department, goals, tasks and workload to be performed, and planned period of the mobility.***

|  |
| --- |
|  |

***(if necessary, please provide additional details on a separate sheet)***

**I attest that the information given in this application is accurate and true.**

Student’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D. ACADEMIC APPROVAL**

The above proposal is approved.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Academic Adviser’s Signature)