

CLINICAL ENRICHMENT EXPERIENCE

MICHIGAN STATE UNIVERSITY/ COLLEGE OF OSTEOPATHIC MEDICINE

Michigan State University student _____ who is a ___3rd / ___4th year Osteopathic Medicine student assigned to _____ Hospital for his/her core clinical clerkship education program, has requested permission to complete an “enrichment” clinical experience in _____ at _____ Hospital on [date(s)] _____ with Dr. _____ serving as the supervising trainer. It is my understanding that this enrichment educational opportunity will not impact the student’s progress in the rotation that he/she is currently completing. I believe the student’s request is consistent and appropriate for the level of his/her training.

Student Signature (required) and Date

No participation and no malpractice insurance coverage without completed form and required signatures prior to the enrichment experience.

Required Signatures:

Director of Medical Education (OR) Med Ed Coordinator (student’s base hospital)

Date

Supervising Physician (OR) Med Ed Coordinator (Enrichment Hospital)

Date

STUDENT: When form is signed please fax to MSU/COM Office of Student Services, C110 East Fee Hall, East Lansing, MI 48824, fax 517-432-1976 and return original to your Medical Education Office at your base hospital. Thank you.