**

 **SINGLE ELECTIVE AFFILIATION AGREEMENT & ROTATION DESCRIPTION**

Windsor University School of Medicine hereby certifies that:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a matriculated student in good standing and

 (Student Name)

has satisfactorily completed all basic science courses, introduction to clinical sciences and appropriate core clinical training rotations and further represents he/she is fully prepared to begin elective clinical training.

Windsor University acknowledges that this student has been medically examined. No condition has been found which would preclude patient contact. The University attests that malpractice insurance is provided. The Dean will review the rotation description below to insure its academic standards are in conformity with its own program and will provide written acknowledgement of approval/disapproval before the program may begin.

Name of Institution:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of the ACGME/Teaching Hospital program, location and sponsoring institution)

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The institution will allow this medical student to do an elective rotation under the supervision of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.D., an authorized and/or appointed member of its physician staff.

Upon completion of the rotation the supervising physician will complete and sign the WUSOM evaluation form and return to the Dean at the address below.

Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Elective Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note the following:

* Participating Student is responsible for any/all program fees
* This Single Elective Affiliation Agreement may not be amended

This agreement will begin on the \_\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_, the first day of the rotation,

continue in effect during the clerkship and will terminate when the program is completed.

By: Windsor University School of Medicine\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name of Institution)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dr.Andy Vaithilingam , Dean School of Medicine Authorized Representative