Weill Cornell Medicine
Graduate School of Medical Sciences
A partnership with the Sloan Kettering Institute

Independent Elective Form

Registration of this Independent Elective will be finalized only when completed forms have been submitted to the Registrar's Office.

Name _____ CWID _____ Date_____
Last, First

To be completed by student:

Starting Date: _____ **Ending Date:** _____

(if applicable):

- Days and times of the week (i.e. Mondays and Fridays at 3pm): _____
- Credit amount: _____

Academic Reasoning for Elective

Attach an abstract or syllabus briefly describing the project you will be working on, how you plan on using your time, proposed timeline and mode of communication with which you will be meeting with your instructor, and learning objectives for this elective.

By signing this document, I confirm that this Independent Elective will be completed in its entirety
Student's Signature:

To be completed Faculty member(s): **In lieu of a live signature below, you may attach a printout of and email specifically stating the approval**

Instructor:

I have agreed to oversee the Independent Elective that is described in the attachment. I have accepted this student under my supervision and will ensure that the student has a well-defined curriculum that supports the goals and learning objectives outlined. The student and I have arranged times and modes of communication. I agree to submit a course grade for the student's work within 4 weeks of completion of the Independent Elective Study course title.

Name:_____ Email: _____

Email:_____ Phone number:_____

Signature: **Date:**

Program:

Major Sponsor (PhD students only): _____ Date: _____

Program Chairperson or Director: _____ Date: _____

Office Use Only: INDE _____ 10/9/2018