

**OFFICE OF MEDICAL EDUCATION
SENIOR SCHOLARS PROGRAM
AY 2009/2010**

DATE SUBMITTED: _____

STUDENT: _____

DEPARTMENT: _____

SENIOR SCHOLARS ADVISOR: _____

*(*for off campus advisor please provide contact info)*

CONTACT INFO: _____

(ADDRESS)

(TEL)

(Email Address)

CLINICAL ROTATIONS TO COMPLETE DEPARTMENT REQUIREMENT:

LOCATION:

TITLE OF INDEPENDENT RESEARCH PROJECT:

BRIEF DESCRIPTION OF OBJECTIVES OF PROJECT:

ANTICIPATED FORUM FOR PRESENTATION OF PROJECT:

PROPOSED INTERVAL OF ADVISOR-ADVISEE MEETINGS DURING FOURTH YEAR:

SIGNATURE OF PROJECT MENTOR(S): _____

PRINT NAME OF PROJECT MENTOR:

DATE

**Poster Presentation Day is scheduled for: May 3, 2010

Please send completed copy of this form by email to Christine.locke@umassmed.edu or return the application to the Office of Medical Education, S1-160.

To receive credit for this elective, it is mandatory that you fill out an elective form for EACH month. Forms should be submitted to: electives@umassmed.edu