OFFICE OF MEDICAL EDUCATION
Clinical Skills Lab
Academic Medicine Request Form-Faculty

Date:

Faculty and block/clerkship name:

Date(s) of event:

Number of AM students requested:

Time students are needed: Where:

Description of activity:

Objectives of activity:
1. 
2. 
3. 

Outcomes expected by the students:
1. 
2. 
3. 

Who will provide the assessment on AM student performances?

Other:

Student Signature ___________________________ Date ____________

Lead Faculty Advisor Signature ___________________________ Date ____________

Academic Medicine Course Director □ Approved □ Denied

Academic Medicine Course Director Signature ___________________________ Date ____________

Comments: