UCSF
SCHOOL OF MEDICINE
University of California, San Francisco

University of California, San Francisco
Approval for Research Block Elective

Name: **Year of Graduation**:
Department: **Course Number**:
Instructor:
Date Scheduled:
Research Site: **Phone**:

In the space below or on an attached sheet, please provide a description of the work that includes all of the following; 1) Research question; 2) Hypothesis; 3) Study design (including basic approaches for statistical analysis, if relevant); 4) Potential impact of work:

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Approval Signature

_____
Primary Investigator/Sponsor Date

_____
Department-chair Date

_____
Director, Physician-Scientist Ed. & Training Program Date

_____
Office of Curricular Affairs Date