

**SCHOOL OF MEDICINE REQUEST FOR EXTENDED PROGRAM**

Student Name: \_\_\_\_\_

Will you stay registered?	Yes	No*
Summer 20__	_____	_____
Fall 20__	_____	_____
Winter 20__	_____	_____
Spring 20__	_____	_____
Summer 20__	_____	_____
Fall 20__	_____	_____
Winter 20__	_____	_____

(\*If you will not remain registered, you must obtain a Withdrawal Petition from the Office of the Registrar.)

- Withdrawal Petition Signed: \_\_\_\_\_ (date)  
 Re-Admit Petition Signed: \_\_\_\_\_ (date)

These plans are \_\_\_\_\_ definite \_\_\_\_\_ tentative (check one)

QUARTER/YEAR you will diverge from normal curriculum: \_\_\_\_\_

QUARTER/YEAR you will return to normal curriculum: \_\_\_\_\_

MONTH/YEAR you will take USMLE Step 2 Clinical Knowledge exam: \_\_\_\_\_

Anticipated date of graduation (quarter/year): \_\_\_\_\_

I have enrolled in the list serve for (subsequent) class of: \_\_\_\_\_ (required)

Contact address, phone, email during extended program (this information is essential):

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

Advisor Signature: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Approved: \_\_\_\_\_ Date: \_\_\_\_\_  
*Helen Loeser, M.D., Associate Dean*

Circulate: MM KH Copy to Financial Aid: \_\_\_\_\_  
 date

\*\*\*Please complete reverse side indicating why you are requesting an extended program\*\*\*

## PURPOSE OF EXTENDED PROGRAM

\_\_\_\_\_ **Health** (Please check one of the following.)

\_\_\_\_\_ Maternity or Paternity

\_\_\_\_\_ Other

\_\_\_\_\_ **Research** (Please write a brief description of your project below, including dates and sponsors. If you plan to remain registered, please complete an Approval for Research Block Elective form, which is available in (S221).

\_\_\_\_\_ **Other** (Please write a brief description of your plans and goals below, including dates and sponsors.)

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**Note about health insurance:** Students participating in research or a scholarly activity are able to sign up for health insurance via the Scholars & Researchers Health Program provided by UCSF Student Health Services. You may download the application from: <http://shs.ucsf.edu> and go to "insurance" to find the SRHP application. **If you are going on leave of absence, you must describe the arrangements you have made for health care as well as the beginning and ending dates of your coverage.**

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**Note about financial aid:** Students can only receive campus-based funding from the Office of Student Financial Services for a total of four years. Please indicate below how you plan to fund your extra year.

Source	Amount (if known)
<input type="checkbox"/> Self/family/friend support	\$ _____
<input type="checkbox"/> Stipend or support from the School of Medicine	_____
<input type="checkbox"/> Outside loans (e.g., Stafford, SLS, etc.)	_____
<input type="checkbox"/> Other (specify)	_____
<input type="checkbox"/> You prefer to receive campus-based funding for your 'extra' year and will use the above sources for your 'fourth' year of medical school.	