DONALD AND BARBARA
ZUCKER SCHOOL *of* MEDICINE
AT HOFSTRA/NORTHWELL

Research Elective Proposal Form

Donald and Barbara Zucker School of Medicine
at Hofstra/Northwell
Advisory Committee for Student Research
500 Hofstra University
Hempstead, NY 11549-5000
email: tiffany.m.jordan@hofstra.edu

Directions: Please fill out the form to the best of your ability. All submissions must be made at least eight weeks prior to the start date of the proposed elective. Your proposal will be reviewed by the Advisory Committee for Student Research in order to determine if you will receive credit for the planned activity. Please visit the committee's website for guidance on how to fill out this form: **http://medicine.hofstra.edu/research/student-research.html**.

Please include the following when submitting this form: Proof of IRB Approval (listing you as a participant) ☐

Please indicate which category your proposal is in: Basic Science ☐ Clinical ☐ Medical Education ☐

Section I: Student Information

Student Name | Date of Submission

Proposed Elective Dates

Section II: Mentor Information

Mentor Name | Mentor Email

Hofstra ID# (if Hofstra Northwell SOM Faculty)

Do you have previous experience working with this mentor? If so, please describe.

Section III: Project Information (to be completed by student - feel free to attach a separate document for the following section)

Project Title

Project Hypothesis

Where will this project take place?

Specific Aims/ Research Questions

Methods (300 words max.)

Section III: Project Information continued (feel free to attach a separate document for the following section)

Predicted Outcomes

What is your role in the project?

Section IV: Student Certification

I understand that the Student Research Advisory Committee will notify me when my proposal has been reviewed. If my proposal is not approved, I understand that I will not be granted credit for this research.

Student Signature _____ Date _____

Section V: Mentor Certification (to be completed by mentor)

Have any Hofstra Northwell School of Medicine students participated in this project in the past? Yes ☐ No ☐

Does this project have IRB/IACUC protocol approval? Yes ☐ No ☐ Has the student been added to the IRB? Yes ☐ No ☐

I understand that, if approved, the student submitting this form will receive research elective credit for this experience. I understand that I will be expected to submit an evaluation for this student and will do so in a timely manner.

Mentor Signature _____ Date _____

For office use:

Decision: ❒ Accepted ❒ Denied

Committee Sign-off *Date*