COMMUNITY ROTATION PROPOSAL AND AUTHORIZATION - RESIDENT

Resident: _____

Program: _____

Dates of Rotation: _____

Site of Community Rotation: _____
(Hospital/University)

_____
(Address)

Supervisor: _____
(Please print or type)

Supervisor Email Address: _____

ACKNOWLEDGEMENT OF SUPERVISOR:

Signature: _____ ***Date:*** _____

APPROVAL OF PROGRAM DIRECTOR

Signature: _____ ***Date:*** _____

==========

FOR USE BY THE POSTGRADUATE MEDICAL EDUCATION OFFICE, MEMORIAL UNIVERSITY, ONLY

Date: _____