ELECTIVE/SELECTIVE PROPOSAL AND AUTHORIZATION - RESIDENT

Resident: _____

Program: _____

Dates of Elective/selective Rotation: _____

Elective/selective Subject: _____

Elective/selective Objectives: _____

_____

Site of Elective/selective: _____
(Hospital/University)

_____
(Address)

Supervisor: _____
(Please print or type)

Supervisor Email Address: _____

ACKNOWLEDGEMENT OF ELECTIVE/SELECTIVE SUPERVISOR:

Signature: _____ Date: _____

APPROVAL OF PROGRAM DIRECTOR

Signature: _____ Date: _____

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

For outside of Province Electives, Authorization will be sent to appropriate licensing authority and PGME Office only upon payment of All University Fees.

Date: _____