

**RESEARCH Proposal and Authorization - Resident**

**Resident:** \_\_\_\_\_

**Program:** \_\_\_\_\_

**Dates of research rotation:** \_\_\_\_\_

**Title of research:** \_\_\_\_\_

\_\_\_\_\_

**Site of research:** \_\_\_\_\_

(Hospital/University)

\_\_\_\_\_

(Address)

**Research objectives:** \_\_\_\_\_

\_\_\_\_\_

**Research – deliverables/outcomes expected:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Supervisor:** \_\_\_\_\_

(Please print or type)

**Supervisor email address:** \_\_\_\_\_

**Acknowledgement of RESEARCH supervisor:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**APPROVAL OF PROGRAM DIRECTOR**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

=====

**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:** \_\_\_\_\_