ELECTIVE PROPOSAL AND AUTHORIZATION

Visiting Resident

Name: ________________________________ Email Address: ____________________

Home University: ____

Program of Training: ____________________________ PGY Level: ________________

Are you in Canada on a Work Permit? ☐ NO ☐ YES - Please submit permit

Elective Subject: ____

Supervisor's Name (Please print): ______________________________________

Date of Elective Rotation: ____

Elective Hospital/Site: ____

☐ I have submitted proof of current ACLS certification (within 2 years) to the PGME office.

ACLS is required for electives in: ANESTHESIA; EMERGENCY MEDICINE; GENERAL SURGERY; INTERNAL MEDICINE; GENERAL INTERNAL MEDICINE (pre-FRCPC certification); OBSTETRICS & GYNECOLOGY; and INTENSIVE/CRITICAL CARE.

☐ I have submitted the Blood Borne Pathogens Serology Expectations Declaration form to the PGME office.

UPON SUBMISSION TO MEMORIAL'S PGME OFFICE, THIS FORM IS SENT TO THE COLLEGE OF PHYSICIANS & SURGEONS OF NEWFOUNDLAND & LABRADOR (CPSNL) TO BEGIN LICENSURE. IF YOUR ELECTIVE IS CANCELLED, PGME WILL NOTIFY THE: CPSNL, HEALTH AUTHORITY, PROGRAM-REGIONAL ADMINISTRATOR, SUPERVISOR & HOME UNIVERSITY.

Resident's Signature: ____________________________ **Date:** ____________________

ELECTIVE SUPERVISOR: (*Email verifications not accepted by the CPSNL; signature only)

☐ I will supervise the above elective.

☐ I request prescription writing privileges during this elective for this resident.

Email: ______________________________________

*Signature: ________________________________ Date: ________________________

PROGRAM DIRECTOR (Resident's Program of Training):

☐ I approve the above elective.

☐ This resident is in good standing with his/her residency program and University.

☐ I request prescription writing privileges during this elective for this resident.

Program Director's Name (Please print): ______________________________________

Email: ______________________________________

Signature: ________________________________ Date: ________________________

SENT TO THE CPSNL, HEALTH AUTHORITY, PROGRAM-REGIONAL ADMINISTRATOR & SUPERVISOR FROM PGME (MUN):

Signature: ________________________________ Date: ________________________