Internal Medicine Residency Training Program
Queen's University
ELECTIVE REQUEST FORM

Resident Name:

PGY Year:

Start date:

End date:

Elective Rotation (i.e. Cardiology)

Hospital incl. city/province:

School/University:

Supervisor's Name:

Supervisor's Email:

Supervisor's Mailing address
(if other than Kingston):

Objectives
(please list specific objectives for
this elective):

Resident's Signature:

Date:

Statement by proposed elective supervisor:

I have reviewed the above elective proposal with the resident and accept responsibility for supervision and evaluation of this elective. The objectives listed above are appropriate and achievable for this rotation. The proposed dates are acceptable.

* Supervisor's signature:

_____

(If unavailable attach documents from proposed university)*

Date:

_____

Program Director's Signature:

_____

Date:

_____

After approval copy will be placed on Resident file