Resident Elective Request Form

(print clearly)

In order for your name to be submitted to the College at the end of your residency an evaluation form for each rotation must be on file. Missing evaluations will delay completion of your residency.

Resident's Name: _____

Street Address: _____

City, Prov, Postal Code: _____

e-Mail: _____@dal.ca

Home Phone # _____

Cell # _____

If you are doing an elective outside your home province, please tick to confirm you have applied for the appropriate medical license: ☐

Specialty: _____

Location: _____

University/Hospital Affiliation: _____

Start Date: _____

End Date: _____

Supervisor's Name: _____

Street Address: _____

City, Prov. Postal Code: _____

e-Mail: _____

Does your supervisor require a confirmation letter from the Department? Yes ☐ No ☐

Please provide an outline of the objectives to be completed on this rotation: