Request for Elective

Pediatric Postgraduate Education Program – McMaster University

Resident Name: _____

Date of Request: _____

Community □

Clinical Elective □

Research Elective □
(Please attach abstract/proposal and letter of Support)

Date from: _____

Date to: _____

Supervisor:_____

Address/Hospital

_____

_____

Telephone #: _____

Clinical/Community elective requires approval by the program director only. Research elective requires approval by research mentor, research supervisor and program director.

_____ _____

Research Mentor Date

_____ _____

Research Supervisor Date

_____ _____

Program Director Date

Please return completed form to Shirley Ferguson, HSC-3N27I