Pediatric Postgraduate Education Program
McMaster University

REQUEST FOR ELECTIVE

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 supervisor, research mentor and program director.

_____ _____

Research Supervisor **Date**

_____ _____

Research Mentor **Date**

_____ _____

Program Director **Date**

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