Undergraduate Medical Education

APPLICATION FOR CLINICAL ELECTIVE

STUDENT NAME: _____

PROPOSED ELECTIVE: _____

LOCATION OF ELECTIVE: _____

DATE OF ELECTIVE: _____

STUDENT SIGNATURE: _____

PHONE: _____ **EMAIL:** _____

PORTION BELOW TO BE COMPLETED BY PROGRAM OR DEPARTMENT:

DETAILS OF PROGRAM: _____

_____

_____

_____

PRECEPTOR: _____

APPROVED BY: _____
Rotation Director/Coordinator

University of Saskatchewan
College of Medicine