

ELECTIVE APPROVAL FORM

Resident: _____

PGY: 1 2 3

Date: _____

Elective Information:

Dates: _____

Location: _____

- U.S. Elective
- International Elective

Supervisor Information:

Name: _____

Contact Info: _____

Main Contact for Evaluations:

Objective:

Long-term Goal:

- Clinical experience
- Publication or presentation at national meeting
- Career advancement (fellowship, job)
- Quality improvement
- Health policy/advocacy
- Other: _____

Resident Signature

Date

Need the following info:

Elective Supervisor Signature

Date

Approved

Denied

Program Director/APD Signature

Date