**ELECTIVE ROTATION**

**RESIDENT PROPOSAL**

**==========================================================================================**

**This form needs to be completed and turned into the Residency Admin Office three (3) months prior to your elective.**

RESIDENT'S NAME:

ELECTIVE TITLE: DATES:

SUPERVISING ATTENDING:

FACILITY NAME:

FACILTY ADDRESS:

FACILITY TELEPHONE:  FACILTY FAX:

FACILITY CONTACT NAME AND EMAIL ADDRESS:

**==========================================================================================**

DETAILED DESCRIPTION OF ELECTIVE (Include how many days a week are in clinic and how many at rotation site):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|   | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| **AM** |   ? | ? | ? | ? | ? | ? | ? |
| **PM** | ?`  | 3:00 pm FH Didactics | ? | ? | ? | ? | ? |

ELECTIVE ROTATION OBJECTIVES:

1) Medical Knowledge:

2) Patient Care

3) Interpersonal and Communication Skills

4) Systems-Based Practice

5) Practice Based Learning and Improvement

6) Professionalism

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Advisor’s approval is required before the Program Director can sign off.

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Advisor’s Name (Please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Advisor’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Director Signature Date

Date received by Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_