

ELECTIVE FORM

(Form must be completed at least two months before start of rotation)

Resident Name: _____

Dates of Rotation: _____

Rotation Title: _____

Rotation Location: _____

Address: _____

Supervisor's Name: _____

Contact Phone: _____

Name of person to contact for copy of schedule: _____

License required in other state? _____

Anticipated number of shifts and hours/week: _____

Elective Rotation Description:

Goals and Objectives:

1) _____

2) _____

3) _____

Resident's Signature: _____ Date: _____

Director's Signature: _____ Date: _____