UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE
DEPARTMENT OF PEDIATRICS

Resident Outside Elective Request Form

Date: _____ College/Dept: Medicine/Pediatrics

Request for: _____ Level: _____
(Resident Name)

Training Program: University of Arizona Pediatric Residency Program

Elective Rotation Name: _____

Elective Rotation Dates: From: _____ To: _____

Elective Site (Provide ***full*** legal site name & address):

_____

_____

_____

Learning Goals and Objectives (attach additional sheets if necessary): _____

_____

_____

Site Supervisor (print name & degree): _____

Title: _____

Phone: _____ Email: _____

Office contact (Name & phone, if applicable): _____

Site GME Contact (Print Name): _____

Phone: _____ Email: _____

APPROVALS:

Program Director Signature must be obtained *BY REQUESTING RESIDENT* before form is submitted to Program Coordinator.

By: _____ DATE: _____
Sean P. Elliott, MD, Program Director