



**Elective/Selective
Application**

Part A (to be completed by the student)

Name: _____ Class: _____

e-mail: _____

Elective/Selective Site: Teaching Hospital General Hospital Clinic
 Primary Care BHU RHC

Name of Hospital/Clinic/Site/Facility of Elective/Selective: _____

Location/Address: _____

Elective/Selective (circle one) in the Discipline of: _____

Name of Elective/Selective Supervisor if known: _____

Email of Elective/Selective Supervisor: _____

Date: From _____ DD/MM/YYYY To _____ DD/MM/YYYY

Total No. of Weeks Planned for Elective/Selective: _____

Define your Objectives for the intended Elective/Selective:

Educational/Training/Personal Objectives: (Describe how this Elective/Selective will contribute towards your Professional Career Goals)

Student's Signature _____ Date: _____

Part B

Approved by Department of Medical Education:

Electives/Selective Coordinator Name:

Signature: _____

Date: _____

In-charge DME Name:

Signature: _____

Date: _____

Part C

To be completed by the Supervisor/Preceptor of the Elective/Selective:

I agree to supervise this student for the intended duration of elective/selective as chosen above, and will also **assess the student** at the end of the elective/selective rotation (Assessment form will be provided by the student)

Signature _____

Date _____