

OUTSIDE ELECTIVE ROTATION REQUEST

Resident Name _____ PGY _____

Program _____ Date _____

Location _____

Dates of Rotation _____ Hours/Week _____

Supervising Faculty _____

Is this elective rotation available at Christ Medical Center, Lutheran General Hospital, or University of Illinois? Yes _____ No _____

Brief description of why you would like to do this elective: _____

Required Attachments: Rotation Goals and Objectives with a rotation description signed by the Supervising Attending
CV of the supervising Attending
Research rotations **ALSO** require a copy of the research proposal/abstract.

Approved:

Program Director _____ Date _____ Designated Institutional Officer _____ Date _____

Director of Medical Education _____ Date _____ Risk Management _____ Date _____