OUTSIDE ELECTIVE ROTATION REQUEST

Resident Name ___________________________________ PGY ______________
Program ____ Date ______________
Location ____
Dates of Rotation ___________________________________ Hours/Week ________
Supervising Faculty ____
Is this elective rotation available at Jackson Memorial Hospital/Jackson Health System or its affiliated institutions? Yes____________ No ____________
Brief description of why you would like to do this elective:____

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Required Attachments:

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

Approved:

_____________________ __________ _______________________ _________
Program Director Date Designated Institutional Official Date