## Saint John Regional Hospital Clerkship Elective Application Form

Queries - e-mail <a href="mailto:qreki@reg2.health.nb.ca">qreki@reg2.health.nb.ca</a>

NOTE: Applications must be received a least THREE MONTHS PRIOR to proposed date of elective. <u>Electives will not be confirmed by telephone.</u>

	dudent e-maii address.	
NAME:Surname		
Surname	First	Initial
DDRESS:		<del></del>
OUR MEDICAL SCHOOL & ADDRE	SS:	<del>-</del>
ENGTH OF MEDICAL COURSE:	(years) EXPECTED GRAD	DUATION DATE:
COMPLETED CLINICAL MEDICAL EI	DUCATION PRIOR TO PROPOS	SED ELECTIVE:
JNIVERSITY TRAINING/DEGREES F	PRIOR TO MED. SCHOOL:	
LERKSHIPS REQUESTED (In Orde		DATES (Month/Day/Year)
·		/
RIEFLY DESCRIBE YOUR GOALS (ecessary.)	AND OBJECTIVES FOR EACH	ELECTIVE LISTED ABOVE. (Attach sheet if

## THIS SECTION TO BE COMPLETED BY THE DEAN OR HIS DESIGNATE OF YOUR MEDICAL UNIVERSITY. A LETTER OF SUPPORT FROM THE DEAN <u>MUST</u> ACCOMPANY THIS APPLICATION.

## **COMPLETED APPLICATION TO BE SENT TO:**

Pamela Bourque
Postgraduate Medical Education
3DS, Medical Education
P.O. Box 2100
Saint John Regional Hospital
E2L 4L2

I CERTIFY THATIN	IS A REGISTERED STUDENT		
THEYEAR OF AYEAR PROGRAM LEA	ADING TO ).		
Malpractice Insurance covers the student away from our	school while taking an approved elective. Yes		
(If unable to obtain malpractice insurance coverage, please	e state reason)		
Assessment of applicant's <b>ACADEMIC ABILITY</b> is: belo	ow average / average / above average		
Assessment of applicant's <b>CLINICAL ABILITY</b> is: below	average / average / above average		
Please rate applicant's <b>EXPERIENCE and SENIORITY</b> :			
General assessment of applicant's CHARACTER AND CONDUCT:			
Is there any further information you think might be relevant			

SIGNATURE:	
TITLE:	
MEDICAL SCHOOL:	SCHOOL SEAL:
DATE:	

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