

Queries – e-mail greki@reg2.health.nb.ca

Student e-mail address: _____

ADDRESS: _____

_____ / _____ / _____ to _____ / _____ / _____
 _____ / _____ / _____ to _____ / _____ / _____
 _____ / _____ / _____ to _____ / _____ / _____

DATE:

THIS SECTION TO BE COMPLETED BY THE DEAN OR HIS DESIGNATE OF YOUR MEDICAL UNIVERSITY. A LETTER OF SUPPORT FROM THE DEAN MUST 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 THAT _____ IS A REGISTERED STUDENT
AT _____ IN _____

THE _____ YEAR OF A _____-YEAR PROGRAM LEADING TO
A _____ (DEGREE).

Malpractice Insurance covers the student away from our school while taking an approved elective. Yes _____

(If unable to obtain malpractice insurance coverage, please state reason)

Assessment of applicant's **ACADEMIC ABILITY** is: below average / average / above average

Assessment of applicant's **CLINICAL ABILITY** is: below average / average / above average

Please rate applicant's **EXPERIENCE** and
SENIORITY: _____

General assessment of applicant's **CHARACTER AND CONDUCT**:

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Is there any further information you think might be relevant to this student's application?

SIGNATURE: _____

TITLE: _____

MEDICAL SCHOOL: _____

DATE: _____

SCHOOL SEAL: