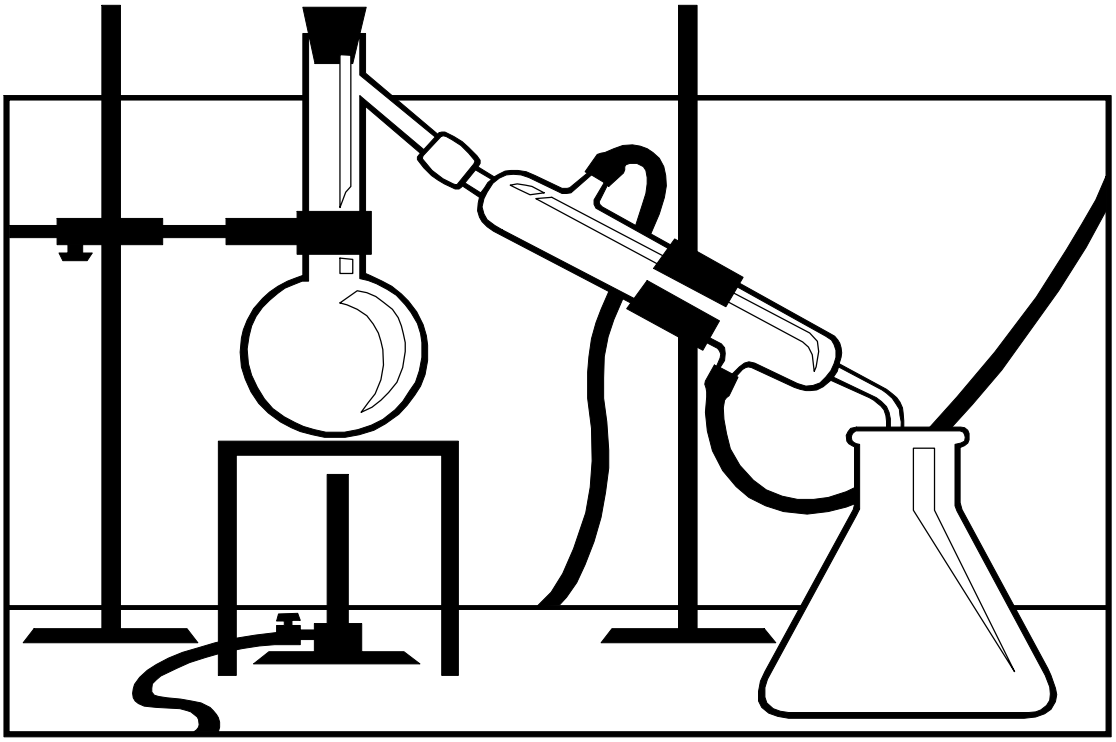
Medical Education Department
Atlantic Health Sciences Corporation

PLEASE RETURN COMPLETED APPLICATION FORM TO:
PAMELA MURPHY
MEDICAL EDUCATION-3DS
PO BOX 2100
SAINT JOHN, NEW BRUNSWICK
E2L 4L2
CANADA
Phone:506-648-6370
Fax: 506-648-6833
Email: murpa@reg2.health.nb.ca



- **INTERNATIONAL MEDICAL ELECTIVES ARE OFFERED FROM SEPTEMBER THROUGH MAY ONLY**

- **STUDENTS MUST BE ENROLLED IN THE FINAL YEAR OF MEDICAL STUDIES AT THE TIME OF THE PROPOSED ELECTIVE**

PLEASE PRINT OR TYPE ALL INFORMATION REQUESTED

SURNAME	FIRST-NAME	INITIAL
FORMER NAME(IF APPLICABLE)	TELEPHONE NUMBER	SEX:(M/F)
PRESENT ADDRESS		

NAME AND ADDRESS OF MEDICAL SCHOOL: _____

_____

_____

LENGTH OF MEDICAL COURSE: _____

GRADUATION DATE: _____

WHAT CLINICAL MEDICAL EDUCATION WILL YOU HAVE COMPLETED PRIOR TO YOUR ELECTIVE? _____

_____

_____

SPECIALITY IN WHICH TRAINING IS REQUESTED: **1.** _____

2. _____

3. _____

DATE REQUESTED: **From:** _____ **To:** _____

STATE THE APPROVED OBJECTIVES FOR THIS ELECTIVE ATTACHING A SEPARATE PAGE WITH THE APPLICATION