Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario

Northern Ontario School of Medicine (UME)
Special Educational Experience Approval Form

Personal Information:

Last Name: First Name: ❑ East Campus ❑ West Campus

Undergraduate training year: ❑ UGY 1 ❑ UGY 2

Special Educational Experience (SEE) Information

Medical School/Network SEE Coordinated Through (i.e. McMaster):

SEETitle:
Start Date: End Date:
SEE Supervisor(s) Name:
Hospital/Clinic Name:
Address: City: Province: Postal Code: Country:
Telephone Number: Fax Number: E-Mail Address:

Student Learning Objectives (Required): (*List here or attach additional sheet if required)*

Disclosure Note: By signing this form, I hereby certify that there is no conflict of interest which may result in the submission of a biased assessment from my supervisor of my performance while on the SEE (e.g. family member, close personal friend, etc.)

Student Signature: Date Signed:

It is the student's responsibility to return this completed form to the NOSM Student Records & Electives Officer, NOSM, East Campus, **no later than 2 weeks prior** to the commencement of the SEE.

Please email or fax your completed application to records@nosm.ca or 807-766-7485.