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

Northern Ontario School of Medicine (UME)
Elective Approval Form

Personal Information:

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

Undergraduate training year: ❑ UGY 2 ❑ UGY 4

Elective Information

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

Elective Title:_____

Start Date:_____ End Date:_____ # of Weeks:_____

Elective 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 Elective (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 months prior** to the commencement of the Elective.

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