



## Special Educational Experience (SEE)

### CLINICAL

### Application and Approval Form

A Clinical SEE allows students to gain exposure in clinical settings that involve patient interaction under the supervision of a licensed/qualified medical practitioner. Clinical SEE allow students to experience different medical disciplines as a means to inform their future career choices. The objectives of the experience must be appropriate for the student's stage of learning. For example, in Phase 1 Clinical SEEs must be predominantly observational in nature.

**Approval Process:** This form needs to be completed and signed by the student(s). Approval is to be obtained by the clinical SEE supervisor (Electronic signature or e-mail approval will suffice). Submit completed and signed form to Learner Records ([records@nosm.ca](mailto:records@nosm.ca)) who will obtain appropriate approval from Phase Lead. *Student MAY NOT begin SEE before approval is obtained from Phase Director.*

1. Student Name: \_\_\_\_\_ Campus: \_\_\_\_\_ Year: \_\_\_\_\_
2. Student Contact Information:  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_ NOSM I.D.: \_\_\_\_\_
3. Title of Project: \_\_\_\_\_
4. Faculty Supervisor Name : \_\_\_\_\_
5. Faculty Supervisor Title & Qualifications: \_\_\_\_\_
6. Faculty Supervisor Contact Information:  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_
7. Location of SEE: \_\_\_\_\_
8. Does a close personal or professional relationship exist between the student and supervisor? Yes \_\_\_ No \_\_\_  
If yes please describe the nature of the relationship:  
\_\_\_\_\_  
\_\_\_\_\_
9. SEE Start Date: \_\_\_\_\_
10. SEE End Date: \_\_\_\_\_

11. SEE category (select one):

(These categories correspond with the disciplines CaRMS uses for matching in Year 4)

**Objectives of SEE**

**APPROVALS**

**Agreement of Student**

As a NOSM student I agree to abide by all applicable NOSM policies and procedures, and I agree to follow the directions of the SEE supervisor. I will immediately report any injuries or safety concerns to my faculty supervisor. *(Electronic Signature accepted)*

Student Name (Please print): \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Agreement of SEE Supervisor**

As the SEE supervisor for this activity, I have read and agree to the information in this application form. I acknowledge and agree to the role of supervisor and the responsibility to ensure that the research is carried out in accordance with all relevant policies and regulations. I understand that I will not be compensated by NOSM as a SEE Supervisor. *(E-mail stating consent is accepted)*

SEE Supervisor Name (Please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**OFFICE USE ONLY**

**Assistant Dean, Phase 1 or Phase 3 Clerkship Director:**

- Is the activity beneficial to the student’s medical education?  Yes  No
- Is the activity appropriate for the student’s stage of learning?  Yes  No
- Is the activity properly supervised?  Yes  No
- Have any health and safety concerns been sufficiently addressed?  Yes  No
- Have any perceived or actual conflicts of interest been declared and addressed?  N/A  Yes  No

I, \_\_\_\_\_, have read, and if necessary, discussed the above SEE – Clinical application with the student and/or faculty supervisor, and I approve this activity.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_