



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) 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: _____