

REQUEST FOR APPROVAL OF AN INTERNATIONAL ELECTIVE

Name of Student: _____

MD: _____ Student Number: _____ Email: _____@uottawa.ca

Start Date: ____/____/____ End Date: ____/____/____
YYYY MM DD YYYY MM DD

Supervisor (MD)'s Name and Title: _____

Department/Organization where the elective will take place:

Complete address of the location where the elective will take place:

Title/Specialty of the Elective: _____

Clinical Elective: _____ or Research Elective: _____

Risk Factors: (or attach document of the risk factors)

Is this your first international elective: YES _____ NO _____

If NO, please specify where elective was done: _____

Complete address of where will you be staying during this elective period:

What are your objectives: _____

*REQUEST MUST BE MADE **AT LEAST 2 MONTHS** PRIOR TO THE ELECTIVE.

Once your application has been received and verified by the Medical Education Office, it will be forwarded to the Global Health Office.

STUDENT MUST RETURN FORM TO:

Electives Coordinator, Undergraduate Medical Education, 451 Smyth Road, Room 2046, Ottawa, ON K1H 8M5

Fax: 613-562-5651

elective@uottawa.ca

Revised October 3, 2011