

**UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE
GRADUATE MEDICAL EDUCATION**

Outside Elective Request Form for an "**INDIVIDUAL**"

Prepared By: _____ Date: _____
Dept: _____ Phone: _____

Request for: _____ Level: _____
(Name of Participant)

Training Program: _____

Elective Rotation Name: _____

Elective Rotation Dates: From: _____ To: _____

Elective Site (Provide **full** legal site name & address): _____

Learning Goals and Objectives (attach additional sheets if necessary): _____

Site Supervisor (Print Name & Degree): _____

Title: _____

Phone: _____ FAX: _____

Office contact (Name & phone, if applicable): _____

Site Contact (Print Name): _____

Phone: _____ FAX: _____

Email: _____

APPROVALS:

By: _____ DATE: _____
Program Director

Print Name: _____

GME Office: _____

AHSC Contracting Office: _____

- If required, Site Approval (must attach documentation from host institution)
- Completed a minimum of 60 days in advance
- If required, Special Provisions have been sent electronically to dbigelow@u.arizona.edu and dvanover@email.arizona.edu.