UNIVERSITY OF THE WEST INDIES

FACULTY OF MEDICAL SCIENCES

ELECTIVE PERIOD REGISTRATION FORM

12-Apr-17

Student's Name _____ Group: _____

Class of _____ Elective period: 5th year No. of weeks _____

Student's Mailing Address _____

_____

Student's Telephone Number (s) _____
(Please provide your most recent contact number(s))

Student's Email Address _____

Choice of Elective _____

Date of Elective _____
(day/month/year – day/month/year)

Number of weeks: 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ 5 weeks ☐

Proposed Objectives and Activities _____

_____

_____

_____

Name of Principal Supervisor/Consultant _____

Signature of Supervisor/Consultant _____ Date: _____

Hospital/Address of Principal Supervisor/Consultant _____

Approved Elective Co-coordinator _____ Date: _____

N.B. Kindly be advised that you will not be allowed to complete an elective period without the approval of the Elective Co-Coordinator and the Principal Consultant.