
# THE WICHITA CENTER FOR GRADUATE MEDICAL EDUCATION

## REQUEST FOR ELECTIVE AWAY ROTATION - DOMESTIC

Name:_____ Program:_____

Dates of requested elective: From _____ To _____

Name and address of elective:_____
(Please print)

_____

Attending/Supervising Physician at elective site:_____
(Please print)

Reason for off-site elective (How does this rotation enhance your education? What are the objectives of this rotation?):

_____

_____

_____

_____

_____

_____

Resident Signature:_____ Date:_____

Approval:

Program Director Signature:_____ Date:_____

WCGME Chief
Operating Officer _____ Date:_____