UNIVERSITY OF ALBERTA

UNDERGRADUATE MEDICAL EDUCATION
FACULTY OF MEDICINE & DENTISTRY

Year 1 or Year 2 Elective

☐ M E D 5 1 7 Year One Elective	☐ M E D 5 1 8 Year 1 Summer Elective	☐ M E D 5 2 7 Year Two Elective

Last Name:	First Name:	Student ID:
Email Address:		Class Year:

Completed forms are to be returned to the UME office AFTER your experience. Forms that are returned without a signature will not receive credit. Please ensure all the information below has been completed.

Title of Elective:		
Hospital or Location of Elective:		
Date(s) of Elective:	Start Time:	End Time:
Print Preceptor's Full Name(s):		
Preceptor's Address:		
Telephone:	Fax:	Email:

If you have any concerns about this student, please document them below

Student's Signature:	Date:
Preceptor's Signature:	Date: