UTHealth | The University of Texas Health Science Center at Houston | Medical School

Internal Medicine Clinical Elective Rotation Approval Form

Resident: ____________________________________ **Dates:** ______________________

Faculty Mentor: ____________________________________

Title of Rotation:

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Location of Rotation:

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Specific Aim of Elective Month:

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BRIEF Summary of Goals and Objectives:

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Approvals:

Resident signature: ______________________________________ **Date:** ________________

Faculty Signature: _______________________________________ **Date:** ________________

Residency Official Signature: ______________________________ **Date:** ________________