

**Pediatric Postgraduate Education Program  
McMaster University**

**Request for Research Elective**

**RESIDENT NAME:**

**DATE OF REQUEST:**

**TYPE OF RESEARCH ELECTIVE:**            **Horizontal**     **Block**

Each of the following must accompany the request:

- Abstract/Proposal
- Research elective objectives\*
- Research Supervisor's letter of Support
- Approval from clinical rotation supervisor or ERP if undertaking horizontal research elective

Elective Date from: \_\_\_\_\_ Date to: \_\_\_\_\_

**Supervisor:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

Contact information: Tel # \_\_\_\_\_; email: \_\_\_\_\_

**\*Research Elective Objectives:**

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**APPROVAL Signatures:**

Program Director/Assistant: \_\_\_\_\_ Date: \_\_\_\_\_

ERP (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

- ***An Evaluation form must be completed by both the resident and the supervisor at the end of the elective.***

**Evaluation form completed:** Resident                       Supervisor

Please return completed form to Shirley Ferguson, HSC-3N27I