Request for Integrated Pediatrics (IP) Rotation

Pediatric Postgraduate Education Program, McMaster University

Please note that this request must be submitted six (6) weeks in advance from your rotation start date. The resident is responsible for arranging the rotation.

ROTATION OBJECTIVES IN CanMEDS FORMAT MUST BE SUBMITTED WITH THIS REQUEST.

If the rotation is within the MacCare/ROMP region, the resident is also responsible for completing the “Request for Elective” form through their website. Approval from MacCare/ROMP must also be given.

Residents are required to attend all mandatory program activities during their IP rotation, unless previously approved by the Program Director. These include AHD, protected teaching sessions (Tuesday morning, Grand Rounds), in-training examinations, call responsibilities etc.

The PGME office will complete the confirmation of registration/Letter of good standing, if needed. It is the resident’s responsibility to ensure that all immunizations and mask fit testing information is current with the PGME office.

The resident can use IP for vacation. Please note this in the rotation section.

The resident can use IP to do clinics, however the resident is required to arrange them and the resident is also required to submit a schedule of clinics for approval with this completed form.

All IP rotations that are not part of a regular MacPeds rotation block will need to be set up by the resident. Residents are required to let the program office know their exact IP rotation schedule and week-to-week schedules once this is known, and at least 4 weeks ahead of rotation.

RESIDENT NAME: ___________________________ Level: _____ Date of submission: _______________

☐ 1 week rotation
☐ 2 week rotation

ROTATION IN: ____________________________________________________________

DATE OF ROTATION from:___________________  to:________________________

ROTATION SUPERVISOR: First name_________________ Last name____________________

SUPERVISOR’S EMAIL: __________________________________________________

HOSPITAL/UNIVERSITY ADDRESS: _________________________________________
Approved by:
Academic Coach/Advisor
Print Name: __________________ Signature: _______________ Date: _______________
(email approval is acceptable – please attach)

Program Director: ___________________________ Date: _______________
(email approval is acceptable – please attach)

Please return completed form to Pediatric Residency Program, HSC-3N48 or to Vanessa Martin at martiv1@mcmaster.ca

Updated Aug 21, 2017