THE UNIVERSITY OF CHICAGO MEDICINE
AT THE FOREFRONT OF MEDICINE®

Internal Medicine Residency Program
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Chicago, Illinois 60637
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RESIDENT ELECTIVE REQUEST FORM

Resident Name:

Dates of Elective:

Faculty Preceptor:

Email Address:

Description of proposed elective:

Goals of proposed elective:

Resident Signature: _____ **Date:** _____

Faculty Signature: _____ **Date:** _____

Chief Resident/ Program Director Signature: _____ **Date:** _____

Please return to Jimmy Jung in A711 two weeks prior to elective time.