NY-PRESBYTERIAN HOSPITAL
FAMILY MEDICINE RESIDENCY PROGRAM

ELECTIVE REQUEST FORM

1. **Resident Name**: _____**Date of Request**: _____

2. **Dates of Elective**: (from) _____ (to) _____

3. **Title of Elective**: _____

4. **Type:** Standard Elective (includes 4 FHC sessions, Thursday conference, 4 elective sessions, 1 admin)? (If sessions outside of NYP needs GME approval 60 days before first day of elective)
_____ Yes _____ No

Farrell Elective (includes 7 FHC sessions, Thursday conference, 2 admin)?
_____ Yes _____ No

Away Elective (International or Out of State) (If yes needs GME approval 90 days before first day of elective for International, 60 days for US)
_____ Yes _____ No

Site Name: _____

Site Address: _____

Site Phone: _____ Site Fax #: _____

5. **Justification for a non-institutional elective:**
_____
_____
_____

6. **Description of Elective**:
_____
_____

7. **Rotation Goals and Objectives** (Please adapt these to the specific elective):

a. Patient Care :- Residents must be able to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.

b. Medical Knowledge :- Residents must demonstrate knowledge of established and evolving biomedical clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

c. Interpersonal and Communication Skills :- Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates.

d. Professionalism :- Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

e. Systems-based Practice :- Residents must demonstrate the awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

f. Practice-based Learning and improvement :- Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life long learning.

8. Rotation Supervisor: Name: _____

Address: _____

Phone: _____ Fax: _____

As supervisor for the above rotation, I am committed to providing timely and thoughtful evaluation of this resident on the form that will be provided by the Family Medicine Department.

_____ _____

Supervisor's Signature Date

9. Advisor Name: _____Advisor's Signature: _____

As the advisor of the above resident, I discussed with the resident the rotation goals and objectives taking into consideration short term and long term career goals.

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					COPC Or ALT FHC
Afternoon					FHC or ALT COPC
Evening					

Week 2

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					COPC Or ALT FHC
Afternoon					FHC or ALT COPC
Evening					

Week 3

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					COPC Or ALT FHC
Afternoon					FHC or ALT COPC
Evening					

Week 4

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					COPC Or ALT FHC
Afternoon					FHC or ALT COPC
Evening					

Reviewed and approved by Beena Jani **90 days** prior to beginning rotation ___Yes ___No

_____

(Beena Jani) Signature Date

As the person responsible for FHC scheduling, I discussed with the above resident their FHC schedule during the elective time requested above, taking into consideration any FHC clinic session that may be affected e.g. Colposcopy; Procedure; MSK and Early Options clinics.
I also reviewed patient care/team coverage if he/she will be away from the FHC.

10. FINAL APPROVAL

_____ _____

PROGRAM DIRECTOR'S SIGNATURE DATE APPROVED