Mercy **Hospital** For Women
MEDICAL ELECTIVE PROGRAM

HOME INSTITUTION APPROVAL FORM

Name of Medical School: .....

Address: .....

.....

To be completed by the Dean or Designate of the Medical School at which the student is currently enrolled

..... is currently in his/her ..... year of ..... year program of studies towards a medical degree (Name of degree: .....)

Assessment of character and conduct: .....

.....

Assessment of academic ability:.....

.....

Student's knowledge of English:

Please attach proof of written and spoken English competency as part of your University's curriculum as well as fill out the criteria below.

Spoken: ☐ Excellent ☐ Good ☐ Poor

Written: ☐ Excellent ☐ Good ☐ Poor

Declaration:

- The above named student is in good standing at this institution and I support without reservation this student for an elective at the Mercy Hospital for Women
- I confirm that the above named student will be a final or penultimate year medical student at the time of the clinical elective.
- I confirm that the above named student is exempt from requiring assessments or learning activities to be signed off during the duration of their elective. Additionally, it is within the discretion of the hospital and its staff to refuse signing off on any assessments as deemed appropriate.

Is there any specific information regarding the student's undergraduate training so far which you believe would be helpful for us to know? .....

.....

.....

Signature: .....

Name (please print): .....

Title: ..... Date: .....

Seal of Medical School