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Department of Medicine
Division of Neurology

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NEUROLOGY RESIDENT ELECTIVE FORM

NAME OF RESIDENT: _____

LEVEL: PGY2 PGY3 PGY4

DATE(S) OF ELECTIVE: _____

SCHEDULED VACATION DURING ELECTIVE: NONE
 YES (Dates): _____

SERVICE/PROJECT: _____

NAME OF SUPERVISOR/ATTENDING: _____

(If Clinical Practice Elective, Include Mailing Address)

Resident Signature & Date

Supervisor/Attending Signature & Date

Residency Prog. Dir. Signature & Date

Chief, Neurology Signature & Date

**Submit this form to the Neurology Administration Office (VA Rm C324 at
least 30 days prior to the beginning of the elective.**