



## Application for Elective Rotation in Dermatologic Surgery

Name:-----

Age:----- Sex:-----

Title:-----

Center/Hospital:-----

Tel.----- Fax.-----

Practice Interests :-----

### Please answer the following Questions with Yes or No:

- |   |     |    |
|---|-----|----|
| 1. I would like to join this rotation to lessen my duties:        | Yes | No |
| 2. I would like to expand my knowledge in this field:             | Yes | No |
| 3. I will try to attend some clinics but no promises:             | Yes | No |
| 4. I will not accept any criticisms in this rotation:             | Yes | No |
| 5. I will join this rotation just to observe cosmetic procedures: | Yes | No |
| 6. I did notify my superiors about this rotation:                 | Yes | No |

### I would like to apply to the following period rotation: Pick one

October      November      December      January      March

April      May

I understand that there is no guarantee that the picked month or this application will be approved by the reviewing committee. Also I will follow the rules and the regulations of the committee. I sign that all of the above is true ,

Dr. \_\_\_\_\_ Date \_\_\_\_\_

### **Committee Review:**

<input type="checkbox"/> <b>Approved application</b>		<input type="checkbox"/> <b>Declined Application</b>
Assigned Rotation Month		
Recommendations		