

Signature Form

Yale Primary Care Research in Residency

Resident Name:

Resident Level (circle): **Intern** **2nd year** **3rd year**

Mentor Name and Title:

Mentor Email Address:

Mentor Phone Number:

Title of Research Proposal:

1. Are you requesting a block of time to do your elective (circle): **YES** **NO**

If yes, which blocks/half blocks are you requesting (limit 2 months total per year):

1a 2a 3a 4a 5a 6a 7a 8a 9a 10a 11a 12a 13a

1b 2b 3b 4b 5b 6b 7b 8b 9b 10b 11b 12b 13b

2. Are you requesting to do a longitudinal elective ½ day per week during your Specialty Office month or Community Office month while on Ambulatory? (circle): **YES** **NO**

If yes, which day of the week and time of day are you requesting:

NOTE: you cannot chose Friday or the afternoon of your primary clinic day.

Monday AM Tuesday AM Wednesday AM Thursday AM

Monday PM Tuesday PM Wednesday PM Thursday PM

Resident Signature: _____ Date: _____

Faculty Mentor Signature: _____ Date: _____