

FCPS- II TRAINING ELECTIVE ROTATION FORM



COLLEGE OF
PHYSICIANS
AND SURGEONS
PAKISTAN

Research
and Training
Monitoring
Cell

IMPORTANT: PROVIDE E-MAIL ADDRESS FOR ACKNOWLEDGMENT

(PRINT IN CAPITAL LETTERS)

DATE OF APPLICATION: _____

Specialty	Chosen specialty for elective rotation
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Duration of Rotational training	FROM	TO	
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FCPS-I SESSION	RTMC REGISTRATION NO.
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DATE OF COMMENCEMENT OF TRAINING (AS ON RTMC REGISTRATION CERTIFICATE)	
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Personal Data	
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NAME	
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FATHER'S / HUSBAND'S NAME	
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PRESENT MAILING ADDRESS	
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(Residential Only)

PHONE	EMAIL
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Institutional & Supervisor Data for Elective Rotation	
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NAME OF TRAINING INSTITUTION	
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NAME OF UNIT / DEPARTMENT FOR ROTATION	
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NAME OF CHOSEN SUPERVISOR WITH DESIGNATION	
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Supervisor's Consent	
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I AM WILLING TO SUPERVISE THE ABOVE NAMED FCPS-II TRAINEE IN THE SPECIALITY OF _____
MY QUALIFICATION ARE :

- I. _____ II. _____
 III. _____ IV. _____

SIGNATURE & STAMP OF SUPERVISOR OF ELECTIVE ROTATION

COUNTER SIGNATURE & STAMP OF MAIN SUPERVISOR

NOTE: ENCLOSE FOLLOWING DOCUMENTS:

- EVIDENCE OF JOINING ELECTIVE ROTATION DULY ENDORSED BY THE SUPERVISOR
- IN CASE OF CHANGE OF INSTITUTE A RE-REGISTRATION IS REQUIRED.

IMPORTANT:

IT IS MANDATORY THAT THE APPLICATION MUST BE SUBMITTED IN THE FIRST WEEK OF COMMENCEMENT OF ROTATIONAL TRAINING.