FORM "RT" — FOR INFORMATION OF ELECTIVE ROTATIONS

FCPS- II TRAINING ELECTIVE ROTATION FORM

COLLEGE OF PHYSICIANS AND SURGEONS PAKISTAN

Research and Training Monitoring Cell

IMPORTANT NOTE: IT IS THE RESPONSIBILITY OF THE CANDIDATE TO ENSURE THAT THE ROTATIONS ARE DONE ACCORDING TO THE PROSPECTUS APPLICABLE TO THEM.

(PRINT IN CAPITAL LETTERS)

DATE OF APPLICATION: ____________

Specialty		Chosen specialty for elective rotation	

Duration of Rotational training ________ FROM ________ TO ________

FCPS-I SESSION ________ RTMC REGISTRATION NO. ________

DATE OF COMMNECEMENT OF TRAINING (AS ON RTMC REGISTRATION CERTIFICATE) ________

Personal Data

NAME ________

FATHER S / HUSBAND'S NAME ________

PRESENT MAILING ADDRESS (Residential Only) ________

PHONE ________ EMAIL ________

Institutional & Supervisor Data for Elective Rotation

NAME OF TRAINING INSTITUTION ________

NAME OF UNIT / DEPARTMENT FOR ROTATION ________

NAME OF CHOSEN SUPERVISOR WITH DESIGNATION ________

Supervisor's Consent

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 :

1. EVIDENCE OF JOINING ELECTIVE ROTATION DULY ENDORSED BY THE SUPERVISOR.
2. 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.