تجمع الرياض الصحي الثاني وزارة الصحة المملكة العربية السعودية



Riyadh Second Health Cluster Ministry of Health Kingdom of Saudi Arabia

External Rotation Competitive Placement Form This section of the form must be completed by the applicant.									
	This section	of the for	m must l	oe complete	d by the	applica	nt.		
Trainee Name:									
Contact Number:				Email:					
Training Site:									
Training Program:									
Program Category:	☐ Fellowship)		Training Y	ear:	□1	st	□ 2 nd	□ 3 rd
	☐ Residency					' '	!	⊔ ∠	
	☐ Diploma					□ 4	th	□ 5 th	
Rotation Start Date:	/ /20			Rotation End Date:			/ /20		
Rotation Objectives: Please describe your specific learning objectives for this rotation									
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Program Status:	□ Joined	Program	☐ Fully	Accredited	Decis	ion:	☐ Appro	ved 🗆	Denied
No. In-House Trainee	ees: No. Rotat					ees:			
	Indicate the p	Indicate the projected number of in-house					Indicate the projected number of external		
		trainees per month during the proposed rotation					rotators per month during the proposed rotation		
	Comn	nents: R	ationale [•]	for approval	or reject	tion			
Signature:				Date:			/	/ 20)
Signature: Note: Acceptance of									
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