

**APPLICATION FORM FOR ELECTIVE STUDENTS**

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| --- | --- |
| **Name** |  |
| **Address** |  |
| **Contact Number** |  |
| **Email Address** |  |
| **Current training provider (with start and end dates)** |  |
| **Previous training providers (with start and end dates)** |  |
| **Qualifications** |  |
| **Areas of interest** |  |
| **Elective start date and end date** |  |
| **Professional reference 1** | 1. |
| **Professional reference 2** | 2. |

Please email the completed form to [ssilverstein@tavi-port.nhs.uk](mailto:ssilverstein@tavi-port.nhs.uk), along with the following information:

* a CV
* a letter from your medical school in support of your application
* a copy of your passport