COVID/Quarantine Elective

Shasta Community Health Center Family Practice Residency Program
1035 Placer Street
Redding, CA 96001
(530) 246-5951 (Office) (530) 245-1068 (Fax)

Resident: _____
Area of Study: _____
Dates: _____
Elective Supervisors: Program Director and Academic Advisor

- **This elective meets the requirements set forth through the ACGME and the ABFM policies.**

I reviewed the following topics and materials that relate to the care of my patients at Shasta Community Health Center: (i.e. books, journals, on-line CME and modules)

_____
_____
_____
_____

After this period of review, I plan to schedule a presentation with Dr. _____, my advisor on the following topic(s):

_____
_____

Additional comments:

_____
_____

I have read the program requirement for elective rotations.

_____ _____
Resident Date

Section 3: Approval by Program Director: _____ Date:_____

Section 4: Final Evaluation: For the resident to get credit for the elective the resident must confirm the date of the presentation. Date_____ Resident initials_____

_____ _____
Program Director Signature Date