WESTERN UNIVERSITY

DEPARTMENT OF PEDIATRICS

PERSONAL LEARNING OBJECTIVES / ROTATION ORIENTATION

Resident:_____ **Clinical Rotation**_____

Rotation Dates:_____

	Personal Learning Objectives (Resident to review with rotation supervisor /head evaluator by end of first week of rotation	**Completed (Y/N)**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

NOTES:

Resident Signature:_____ **Date:**_____

Supervisor Name: _____ **Supervisor Signature:** _____

PRINT

** Complete and return to Belle Smaill on last day of rotation (*519-685-8156*, belle.smaill@lhsc.on.ca)*