MINISTRY OF HEALTH

Kuwait Institute for Medical Specialization







كلية الطب النفسى

Start of Rotation Form

Name of resident:		
PGY: 1 2 3	<u> </u>	<u> </u>
Name of Supervisor:		
Rotation:		
Start Date: DD/MM/YYYY	End Date:	DD/MM/YYYY
This to certify that I have reviewed with	th the resider	nt the objectives of this rotation.
Residents Signature and Stamp		Supervisor Signature and Stamp

Please return this form to the program director within two weeks of the rotation start date.