☐ Elective
☐ Surgical Subspecialty (OMS IV ONLY)
☐ Medical Subspecialty (OMS IV ONLY)

Touro College of Osteopathic Medicine
Hospital Elective Rotation Request Form

Student Name: _____ Class Year _____
Date Submitted: _____ ID No._____ Line No. _____

ALL INFORMATION IS REQUIRED. INCOMPLETE FORMS WILL BE RETURNED. THIS FORM IS DUE NO LESS THAN THIRTY (30) DAYS PRIOR TO THE ANTICIPATED ROTATION START DATE.

Rotation Requested: _____ Requested Month: _____

Hospital/Office Site

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Email: _____

Preceptor

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Email: _____
AOA/AMA No.: _____ State Licensed: _____

Note: Student will be given the responsibility to assist in gathering the documentation necessary for credentialing the preceptor. The preceptor must be properly credentialed no less than thirty (30) days prior to the anticipated rotation start date or the rotation will be cancelled.

In making your selection we would like you to explain your choice prior to approval.

Submission of this request does not constitute approval. Plans for travel or housing should not be made until the student is in receipt of a signed copy of this form indicating approval.

_____
Signature of Student Date

TOURO APPROVAL
Approved ☐ Denied ☐ _____
Signature of Clinical Dean Date

SITE APPROVAL
Approved ☐ Denied ☐ _____
Signature of DME/Preceptor/Elective Faculty Date

Rev. 11/10/10