Touro College of Osteopathic Medicine
Hospital Elective Request Form

Student Name: ____ Class Year: ______________
Date Submitted: ______________________ ID Number: _____________

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 Subject Requested: _______________________________________ Rotation Month: _________________________

Hospital/ Office Site:
Name: ____
Address: ____
City: ____ State: __________________________ Zip: ____________________

Point of Contact:
Name: ____ Title: ____
Phone: (Office) ___________________________________ Phone: (Other) ____
E-Mail: ____ Fax: _______________________________________

Preceptor/Attending:
Name: ____ Title: ____
Phone: (Office) __________________________________ Phone: (Other) ____
E-Mail: ____ Fax: ____
AOA/AMA No.: __________________________________ License #: ____

In making your selection, we would like you to explain your choice prior to approval.
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Submission of this request does not constitute approval. Plans for travel or housing should not be made until the student is in receipt of the signed copy of this form indicating approval.

____ **Date:** ______________
Signature of the Student

○ Approved
____ **Date:** ______________
Signature of Clinical Dean /School Official
○ Declined

○ Approved
____ **Date:** ______________
Signature of DME/ Preceptor/ Elective Faculty
○ Declined

Submit Completed Request to:
Cynthia Figueroa, Clinical Coordinator, 230 West 125th Street, Harlem, New York 10027 by *E-mail*: cynthia.figueroa2@touro.edu or by *Fax*: **646-745-8704**