|  |  |
| --- | --- |
| Request to Attend Non-Core Clinical Rotations |  |

# Instructions

Student should complete Part 1 of this form; Host Site should fill out part two. Upon completion, please send completed form and a copy of the Evaluating Physician’s Medical License to April Watson, Director of 4th Year Rotations: [awatson@carolinas.vcom.edu](mailto:awatson@carolinas.vcom.edu) or fax to 864-804-6991. The Director will notify the student of approval/denial.

# Part 1 (filled out by student)

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name |  | Date of form submission |  |
|  |
| Student Email |  | Student Phone Number |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Requested Rotation Specialty |  | Rotation Start Date |  |
|  |
| Rotation Requirement (Elective, Med Selective, Surg Selective, etc.) |  | Rotation End Date |  |

# Part 2 (filled out by host site)

|  |  |  |  |
| --- | --- | --- | --- |
| Site Name |  | Site Phone number |  |
| Evaluating Physician (name, MD/DO) |  | Medical License attached? |  |
| Street Address  Including City, State,  and ZIP Code |  | Fax Number |  |
| Office Email Address |  | Office contact (name) |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature of Evaluating Physician or Host Site Director |  |  | Date |  |