

Rotation Change Request Form



Please complete this form for all rotation change requests. This form must be reviewed and signed by your DSME, Site Coordinator, and Clinical Affairs personnel. This form must be submitted for consideration at least (4) weeks in advance. Completion of this form does not constitute an automatic approval.

First Name

Last Name

Type of Request:

Rotation Period Switch and/or Rotation Site/Practice Change

CURRENT Rotation Information	REQUESTED Rotation Information
Discipline:	Discipline:
Site:	Site:
Rotation Dates:	Rotation Dates:

Reason for the Request:

Student Signature

Date

Please submit this completed form to the Clinical Affairs office associated with your current rotations

	3 rd Year Contact	4 th Year Contact
Auburn Campus	Sam Kuhn skuhn@auburn.vcom.edu	Amanda Schwiening aschwiening@auburn.vcom.edu
Carolinas Campus	Joy Radcliff jradcliff@carolinas.vcom.edu	April Watson awatson@carolinas.vcom.edu
Virginia Campus	Ashley White awhite@vt.vcom.edu	Jess Nicholson jnicholson@vt.vcom.edu

Site and VCOM Use ONLY

		<input type="checkbox"/>	<input type="checkbox"/>
DSME (Core Site)	Date	Approved	Denied
		<input type="checkbox"/>	<input type="checkbox"/>
Site Coordinator (Core Site)	Date	Approved	Denied
		<input type="checkbox"/>	<input type="checkbox"/>
Director of Clinical Rotations	Date	Approved	Denied
		<input type="checkbox"/>	<input type="checkbox"/>
Associate Dean	Date	Approved	Denied