WCUCOM 4th Year Rotation Request Form

Date Received (office use only):___________

This box must be filled in completely.

Student Name:	Name of Rotation (see list of approved WCUCOM Elective Rotations):
Preceptor's Full Name: Email:	Rotation Type (check all that apply): ☐ VSAS ☐ AOA ☐ Nonclinical ☐ Medicine ☐ Surgery
Rotation Start Date:	Rotation End Date:
Clinic/Hospital Name:	Has this rotation been approved by the facility? ☐ Yes ☐ No
Address:	
Contact/Coordinator Name:	Contact/Coordinator Phone: Email:

Weekly Tracking Sheet

Week	Date	Rotation Title	Med/Surg
1			
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Office Use Only:

Signature: ________________________________
Director of Clinical Rotations
Date: _____________ ☐ Approved ☐ Denied

Signature: ________________________________
Associate Dean, Clinical Sciences
Date: _____________ ☐ Approved ☐ Denied

Notes:

Affiliation Agreement on file? YES NO

Guidelines:

- ✓ 16 weeks Medicine
- ✓ 16 weeks Surgery
- ✓ 4 weeks Medicine, Surgery, or Nonclinical
- ✓ 36 total weeks of electives
- ✓ AOA Approved Residency
- ✓ 5 weeks' flexible time
- ✓ 2-week, 3-week, or 4-week rotations

Send completed form to your assigned counselor: Courtney Shoemaker, cfortune@wmcarey.edu; Kailen Reves, kreves@wmcarey.edu; Meghan Merritt, memerritt@wmcarey.edu