4th Year Rotation Request Form

Student Name (Please Print) ____________________________________ Todays Date __________________

E-mail Address: ___________________________ Phone Number (___) _______ - ________

Rotation Begin Date ___________________________ Month(s): ______________________

Rotation End Date ___________________________ Month(s): ______________________

Rotation Type: ______________________________________________________________________

Preceptor’s Name:
________________________________________________________________________________

Clinic/Hospital Name: ________________________________________________________________

Address: __________________________________________________________________________

Phone #: ___________________________ Fax #: ____________________________________________

Preceptor’s Email Address: ____________________________________________________________

Contact/Coordinator E-Mail Address: ____________________________________________________

Contact Phone #: ___________________________ Fax #: ____________________________________

________________________________________________________________________________

The remainder of this form is to be completed by the Clinical Rotations Office

Signature: ___________________________ Date: __________ Approved ___ Denied
Director of Clinical Rotations

Signature: ___________________________ Date: __________ Approved ___ Denied
Associate Dean for Clinical Sciences

Send completed form to:
Director of Clinical Rotations, WCU Box 207, 498 Tuscan Avenue, Hattiesburg, MS 39401 email as an electronically signed request to jhill@wmcarey.edu OR fax to 601-318-6012.

Office Use Only:

Affiliation Agreement on file? YES NO
Applying through VSAS?: ___________________________