

Please print neatly

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 Requested: _____ **Rotation Dates:** _____

Hospital/ Clinical Site: Name: _____
Address: _____
City & State: _____

Point of Contact:

Name: _____ Title: _____
Phone: (Office) _____ Fax: _____
E-Mail: _____

Preceptor:

Name: _____ Title: _____
Phone: (Office) _____ Phone: () _____
E-Mail: _____
AOA/AMA No.: _____ License #: _____

In making your selection we would like you to explain your choice prior to approval.

_____ [please attach if you require additional lines]

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.

Signature of the Student Date: _____

Signature of DME/ Preceptor/ Elective Faculty Approved Declined Date: _____

Signature of the Dean Approved Declined Date: _____

Submit Requests to:

Harlem Campus
Rhonda Weiss, Student Coordinator,
E-mail: rhonda.weiss31@touro.edu

Middletown Campus
Ashley Wittens, Student Coordinator,
E-mail: ashley.wittens@touro.edu

Recorded on New Innovations: _____