Touro University California College of Osteopathic Medicine
Rotation Request Form

Student Name: _____ ID #: _____*Date Submitted: _____

THIS FORM IS DUE NO LESS THAN SIXTY (60) DAYS PRIOR TO THE APPLICATION DEADLINE FOR YOUR VISITNG CLERKISHIP OR YOUR 3RD OR 4th YEAR ROTATION START DATE.

*Rotation (Specialty) Requested: _____*Requested Dates: _____

* Course #: _____

Site Name: _____

Address: _____

City: _____ State: _____Zip: _____

Phone: _____ Fax: _____

Preceptor Full Name & Degree: _____

Preceptor Email Address: _____

Address to send paperwork to

Name: _____

Contact/Coordinator Name: _____Email: _____

Address: _____

City: _____ State: _____Zip: _____

Phone: _____Fax: _____

Note: Student may be given some responsibility to assist in paperwork necessary for credentialing of preceptor. Preceptor must be properly credentialed no less than thirty (30) days prior to the anticipated rotation start date or rotation may be cancelled.

_____

Student's Signature (* **required if Rotation Request is submitted not via email**): _____

☐ Approved ☐ Denied

Clinical Education Associate Dean Signature: _____Date: _____

Submission of this request does not constitute approval.