



MOUNT CARMEL

ROTATION APPLICATION

Name _____
Last First MI

LCME/AOA-approved
Medical School _____ Class of _____

ROTATION REQUESTED

Specialty _____ From _____ to _____

If this rotation is not available during the dates given, please indicate alternate rotation.

Alternate _____ From _____ to _____

Present Address	Permanent Address (if different)
_____	_____
_____	_____
_____	_____

Phone () _____ Phone () _____

Email _____

Please send correspondence to my _____ present address _____ permanent address.

Upon receipt of this application and written verification from your medical school of professional liability insurance and good standing, we will process your request. If we are able to accommodate your primary or alternate request, we'll send you a confirmation and information packet within 4 weeks. If we cannot accommodate your request, we will notify you by email immediately.

Be sure to have the appropriate school official complete the second page of this application.

Student signature

Date

**The *Medical Student* should email completed application to:
medstudmeded@mchs.com**

ROTATION APPLICATION (PAGE 2)

To be completed by Clinical Clerkship Director or appropriate college official.

This student is in good standing and has approval to schedule the rotation or alternate rotation listed on the reverse side of this application.

Signature of authorized official

Date

Printed name of authorized official

Telephone Number

Title

The *Clinical Clerkship Director/Appropriate College Official* should either mail or fax this form to Mount Carmel Medical Education.

You may mail this form to: Mount Carmel Medical Education
793 West State Street
Columbus, Ohio 43222

Or, you may fax this form to: 614-234-2772