



PHILADELPHIA COLLEGE OF  
OSTEOPATHIC MEDICINE

## APPLICATION FOR ELECTIVE ROTATIONS

(Please select one specialty per application. You should submit a separate application for each rotation you would like to obtain)

Name	E-mail Address	
Current Street Address		
City	State	Zip Code
(    )    -	(    )    -	
Cell Phone Number	Alternate Telephone Number	
Medical School	Year of Graduation	

### ROTATION REQUEST

<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Outpatient Orthopedic Surgery	<input type="checkbox"/> Radiology
<input type="checkbox"/> Nephrology	<input type="checkbox"/> Pulmonary Medicine	

### DATE REQUEST

	1st Choice	2nd Choice	3rd Choice
Start Date	_____	_____	_____
End Date	_____	_____	_____

Email or fax your completed application to:

Email: [studentelectives@pcom.edu](mailto:studentelectives@pcom.edu)

Fax: (215) 871-6781

For more information, contact:

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