APPLICATION FOR ELECTIVE ROTATIONS

Date: _____

Please Print

Name | E-mail Address

Current Street Address

City | State | Zip Code

( ) - | ( ) -

Cell Phone Number | Alternate Telephone Number

Medical School | Year of Graduation

ROTATION REQUEST(S)
(Please specify 1st, 2nd, 3rd, etc. choice)

_____ Anesthesiology

_____ General Internal Medicine

_____ General Surgery

_____ Geriatrics

_____ Infectious Disease

_____ Nephrology

_____ Neurosurgery

_____ Ophthalmology

_____ Orthopedic Surgery

_____ Osteopathic Manipulative Medicine

_____ Otolaryngology

_____ Pathology

_____ Plastic/Reconstructive Surgery

_____ Pulmonary Medicine

_____ Radiology

_____ Surgical Critical Care

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

Email or fax your completed application to:

Email: studentelectives@pcom.edu
Fax: (215) 871-6781

For more information, call:

Antoinette Bivens
Clinical Education Specialist
Philadelphia College of Osteopathic Medicine
4170 City Avenue, Suite 205
Philadelphia, PA 19131
Phone (215) 871-6580

A valid I.D. from your school must be worn while you are on a PCOM rotation

PCOM PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE