



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"/> Nephrology | <input type="checkbox"/> Plastic/Reconstructive Surgery |
| <input type="checkbox"/> General Internal Medicine | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Pulmonary Medicine |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Surgical Critical Care |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Pathology | |

DATE REQUEST

	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