PCOM
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

_____ Anesthesiology
_____ General Internal Medicine
_____ General Surgery
_____ Infectious Disease
_____ Nephrology
_____ Ophthalmology
_____ Orthopedic Surgery
_____ Otolaryngology
_____ Pathology
_____ Plastic/Reconstructive Surgery
_____ Pulmonary Medicine
_____ Radiology
_____ Surgical Critical Care

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:

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