



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 _____

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Cell Phone Number _____ Alternate Telephone Number _____

Medical School _____ Year of Graduation _____

ROTATION REQUEST

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

DATE REQUEST

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

PURPOSE OF ROTATION

Audition Rotation Non-Audition Rotation

Email or fax your completed application to:

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

For more information, call:

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