

APPLICATION FOR ELECTIVE ROTATIONS

Please Print

Date: _____

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)

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

	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) 871-6850

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



PHILADELPHIA COLLEGE OF
OSTEOPATHIC MEDICINE