Date Received: _____

4th Year Rotation Request Form

Student Name (Please Print) _____ Todays Date_____

E-mail Address: _____ Phone Number (____) _____ - _____

Rotation Begin Date _____ Month(s): _____

Rotation End Date _____ Month(s): _____

Rotation Type: _____

Preceptor's Name:
_____

Clinic/Hospital Name: _____

Address:
_____

Phone #: _____ Fax #:_____

Preceptor's Email Address: _____

Contact/Coordinator E-Mail Address: _____

Contact Phone #: _____ Fax #: _____
_____

The remainder of this form is to be completed by the Clinical Rotations Office

Signature: _____ **Date:** _____ ____**Approved** ____**Denied**
Director of Clinical Rotations

Signature: _____ **Date:** _____ ____**Approved** ____**Denied**
Associate Dean for Clinical Sciences

Send completed form to:
Director of Clinical Rotations, WCU Box 207, 498 Tuscan Avenue, Hattiesburg, MS 39401 email as an electronically signed request to jhill@wmcarey.edu OR fax to 601-318-6012.

Office Use Only:

Affiliation Agreement on file? YES NO

Applying through VSAS?: _____