Scope of Elective Rotation Form

(This completed form with the required signatures listed above must be received at least 30 days prior to the proposed start of the rotation by the Medical Staff Office, Memorial Healthcare, 826 W. King Street, Owosso, MI 48867. Email: rsteele@memorialhealthcare.org; Phone: 989-729-4839; ext. 1839, Fax: 989-725-2382)

Name of Student/Trainee: ________________________________ Date Form Submitted: ________________

Permanent Address	
Telephone Number	
Study Plan School/Training Program	
School/Training Program Address	
Telephone Number	
School/Training Program Designated Institutional Official (DIO)	
Student/Trainee's Level/Year of Training	
Title of Proposed Elective Rotation	
Proposed Dates of Elective Rotation	
Rotation Preceptor	
Specialty/Subspecialty	

List all Memorial Healthcare locations/facilities where rotation is to take place (Inpatient, O.R., E.R., L&D, Nursery/Pediatrics, Behavioral Health Unit, Specific Outpatient Offices):

Elective Rotation Objectives:

Description of Proposed Elective Rotation (include work hours/day, days/weeks, etc.):

Planned resources (Books, Internet, etc.):

Evaluation Method (Written/oral exam, paper, clinical, etc.):

Student Signature:____ Date:__________________

School/Training Program DIO Signature:______________________________Date:__________________

I agree to directly supervise this student/trainee for this elective rotation to assist him/her in reaching the stated objectives using the plan, resources, and evaluation methods as described above.

Preceptor's Signature:____ Date:__________________

*** Please note that students/trainees that are on rotation less than 30 days will not receive EMR access***

Approved Memorial Healthcare DIO:_________________________________ Date:__________________