Scope of Elective Rotation Form

****Form must be received 30 days prior to rotation start date with required signatures****

Submit the completed form to the Medical Staff Services Department
826 W. King St, Owosso, MI 48867
Lbond@memorialhealthcare.org Phone: (989) 729-4839 Fax: (989) 725-2382

Name of Student/Trainee: Date Form Submitted:

Permanent Address	
Telephone Number	
Email Address	
School/Training Program	
School Training Program/Address	
School/Training Program DIO/Clinical Faculty	
Student/Trainee's Level/Year of Training	
Title of Proposed Elective Rotation	
Rotation Preceptor	
Specialty/Subspecialty	
Proposed Dates of Elective Rotation	

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

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 Faculty Signature: Date:

Preceptor's Signature: Date:

Approved Memorial Healthcare DIO: Date: