



ARROWHEAD REGIONAL MEDICAL CENTER
Office of Graduate Medical Education

MEDICAL STUDENT ROTATION REQUEST

Please complete this form to request your rotation.

All requests MUST be submitted on or after the open application date.

Once your request is processed, you will be notified via email if your request has been approved or denied.

ROTATIONS ARE SUBJECT TO CANCELLATION IF YOUR SCHOOL PAPERWORK IS NOT RECEIVED.

ONE REQUEST PER APPLICATION

TODAY'S DATE: _____

PERSONAL INFORMATION

Name:	
Home Address:	<input type="checkbox"/> MSIII <input type="checkbox"/> MSIV <i>(Year you will be when on this rotation @ ARMC)</i>
DOB:	Last 4-Digits SSN:
Email:	Contact Phone:

MEDICAL SCHOOL INFORMATION

School Name / Campus: Western University of Health Sciences (Which campus)
School Coordinator: Rotations Coordinator
Coordinator's Email: COMPsite@westernu.edu

ROTATION REQUESTED: (Please indicate 1st, 2nd & 3rd choice disciplines)

MSIII:	<input type="checkbox"/> Emergency Medicine (After Feb ONLY) <input type="checkbox"/> IM – Medicine <input type="checkbox"/> Anesthesia <input type="checkbox"/> PM & R <input type="checkbox"/> General Surgery – ENT (ONLY AFTER Core GSx) <input type="checkbox"/> Ophthalmology (after Dec ONLY) <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Orthopedics
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MSIV:	<input type="checkbox"/> IM – Medicine <input type="checkbox"/> IM – TSS <input type="checkbox"/> IM – MICU <input type="checkbox"/> IM – Cardiology <input type="checkbox"/> IM – Neurology <input type="checkbox"/> IM – GI <input type="checkbox"/> Pediatrics /NICU (CV must be attached) <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Orthopedics <input type="checkbox"/> Emergency Medicine (Board Score _____) <input type="checkbox"/> Family Med. – Inpatient <input type="checkbox"/> Family Med. – Outpatient <input type="checkbox"/> General Surgery <input type="checkbox"/> General Surgery – ENT <input type="checkbox"/> General Surgery – SICU <input type="checkbox"/> Psych <input type="checkbox"/> OB/GYN (GYN Surg.) <input type="checkbox"/> OB/GYN (MFM) <input type="checkbox"/> OB/GYN (Research) <input type="checkbox"/> Anesthesia <input type="checkbox"/> Pain Management <input type="checkbox"/> Pathology <input type="checkbox"/> PM & R
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Will this Rotation be a/an: Elective SUB-I Audition

ROTATION DATES REQUESTED:

Rotations start every Monday and 4 weeks long.

If your 1st choice of rotation dates is unavailable; your 2nd and 3rd choices will be considered.

1st:	2nd:	3rd:
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COMPLETE AND RETURN APPLICATION TO: Medical Student Coordinator at medstudents@armc.sbcounty.gov

BELOW FOR OFFICE USE ONLY

(Western)
 Date Request Received by GME: _____

Approved: YES \ NO