

RRH Rotation Request Form 23-24 Academic Year

Thank you for your interest in rotations with Rochester Regional Health! Complete this form in its entirety and send to GraduateMedical.Education@rochesterregional.org for review.

Full Name: _____ Date: _____
Last First M.I.

Cell Phone: _____ Email: _____

LECOM Campus: Bradenton Elmira Erie Seton Hill Other _____

Clinical Education Coordinator: _____

Clinical Core Campus: Rochester UMMC Other: _____

Current OMS: 1st Year Student 2nd Year Student 3rd Year Student 4th Year Student

Current Other Student Type: _____

Rotation Information

First Choice: _____ Core Elective Selective Senior Capstone Sub-I
Specialty

1st Preferred Time Slot: _____ 2nd Preferred Time Slot: _____

Indicate OMS Year At Time of Rotation: _____

Second Choice: _____ Core Elective Selective Senior Capstone Sub-I
Specialty

1st Preferred Time Slot: _____ 2nd Preferred Time Slot: _____

Indicate OMS Year At Time of Rotation: _____

Third Choice: _____ Core Elective Selective Senior Capstone Sub-I
Specialty

1st Preferred Time Slot: _____ 2nd Preferred Time Slot: _____

Indicate OMS Year At Time of Rotation: _____

Fourth Choice: _____ Core Elective Selective Senior Capstone Sub-I
Specialty

1st Preferred Time Slot: _____ 2nd Preferred Time Slot: _____

Indicate OMS Year At Time of Rotation: _____

Additional Information

When requesting an Interventional Radiology Elective or Sub-I, student must affirm they are interested in applying to our Radiology Residency by checking yes below.

Yes, I affirm No, I do not affirm

I certify that the above information is correct to the best of my knowledge at the date of this request. I also understand that completing this form does not guarantee an offer of placement by Rochester Regional Health.

Signature _____

Date _____