



CHANGE OF ROTATION APPLICATION

(Submit to the Department of Clinical Education)

Student Name: (Please Print) _____

I am requesting to CHANGE Clerkship Rotation: _____

I am requesting to SWAP Clerkship Rotation: _____

Signature: _____

Date: _____ Email address: _____

Phone number: _____

Current Rotation Number: _____

Change to Rotation Number: _____

From: _____ To: _____

From: _____ To: _____

(Facility Name)

(Facility Name)

(Preceptor: First and Last Name)

(Preceptor: First and Last Name)

(City)

(City)

This CHANGE is being requested because: _____

I will be swapping with fellow student _____, who by their signature has agreed to accept my current schedule for this rotation.

Signature: _____

Approved by Rural Health _____

Approved by Department _____

Not Approved Date: _____