



**ST. JOSEPH'S MERCY OF MACOMB  
ELECTIVE OSTEOPATHIC UNDERGRADUATE ROTATION REQUEST**

*(Please type or print & submit at least two months prior to the start of the rotation.)*

A member of the Henry Ford Trinity Health Network  
Office of Medical Education

MS-III (at rotation)       MS-IV (at rotation)

Applicant's Name: Last, First, Middle

Permanent Street Address

Telephone Number at Permanent Address (including area code)

City

Telephone Number at Present Address (including area code)

State & Zip Code

FAX Number (including area code)

E-mail Address

Pager – or -  Cell

Social Security Number

AOA Number

Date of Birth (optional)

College of Osteopathic Medicine

Class of (year)

**HOUSING**

Housing required?       No       Yes, please specify:       Male       Female

**ROTATION REQUEST(S)**

START DATE	END DATE	SPECIALTY REQUESTED	PREFERRED PRECEPTOR	OFFICE USE
				<input type="checkbox"/> Approved or <input type="checkbox"/> Denied <input type="checkbox"/> Confirmed w/Preceptor <input type="checkbox"/> Confirmed w/COM or student Initials:
				<input type="checkbox"/> Approved or <input type="checkbox"/> Denied <input type="checkbox"/> Confirmed w/Preceptor <input type="checkbox"/> Confirmed w/COM or student Initials:

**ADDITIONAL DOCUMENTATION REQUIRED**

- Dean's letter
- Documentation of liability insurance coverage for dates of rotation
- Signed Release Agreement if from an unaffiliated College of Osteopathic Medicine
- Proof of health status and immunization record
- Evaluation of Site (by student, at close of rotation)
- Evaluation of Clinical Performance (by preceptor, at close of rotation)

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

**For Office Use:**

- |   |   |
|---|---|
| <input type="checkbox"/> Completed & signed request form                                      | <input type="checkbox"/> Dean's letter  |
| <input type="checkbox"/> Documentation of liability insurance coverage                        | <input type="checkbox"/> Documentation of health status, incl. TB screen; hepatitis vaccine received/declined; varicella; rubella immunization) |
| <input type="checkbox"/> Evaluation of clinical performance, by preceptor @ close of rotation |   |
| <input type="checkbox"/> Evaluation of site by participant @ close of rotation                |   |

**PLEASE SEND COMPLETED FORM TO J. G. GAMBLE AT FAX (586) 263-2614 OR [e-mailgamblej@trinity-health.org](mailto:emailgamblej@trinity-health.org).**