

MICHIGAN STATE UNIVERSITY / COLLEGE OF OSTEOPATHIC MEDICINE
CLINICAL CLERKSHIP PROGRAM
APPLICATION FOR CLINICAL CLERKSHIP ROTATION

Part I – To be completed by student:

Date _____

Student's Name _____

Mailing _____ Phone # (_____) _____

Address _____ Pager # (_____) _____

Email Address _____

Application is made for a clerkship / rotation in _____
(name of service)

to be conducted at (indicate below):

_____ Hospital (name) _____

_____ Office/Clinic (address) _____

under the supervision of _____
(print name of supervising physician)

Length of training: _____ weeks Beginning _____ Ending _____
(# of weeks) (month/day/year) (month/day/year)

Please list all rotations scheduled for completion prior to this rotation: _____

Part II – To be completed by physician/hospital:

Pending confirmation by MSU/COM, above student is confirmed for rotation indicated:

_____ (date) _____ (Signature of Supervising Physician) (_____) _____ (_____) _____
(telephone number) (fax number)

_____ (date) _____ (Signature of Director of Medical Education or other hospital/clinic/office representative) (_____) _____ (Email)

Hospital Address _____

Return completed form to: MSU/COM – Clinical Clerkship Program Office of Student Services C110 East Fee East Lansing, MI 48824 517/353-7741 (FAX – 517/432-1976) E-Mail: <i>clerkship@hc.msu.edu</i>	When approved, confirmation will be sent to: ____ Student ____ Supervising Physician ____ DME/Hospital Representative ____ MSU/COM Department
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NOTE: Student may not begin until all required signatures are on file in the Clinical Clerkship Program, Office of Student Services.

(Please do not write below this line)

Part III – To be completed by MSU/COM Clinical Clerkship Program:

Course # _____ Section # _____ Cr's _____ Semester _____

Rotation approved and added to student's schedule:

Instructor of Record: _____ Date _____

Clinical Clerkship Program: _____ Date _____