UF UNIVERSITY of FLORIDA

College of Medicine - *Jacksonville*

Office of Educational Affairs

EXTERNAL ROTATION REQUEST FORM

Resident Name: _____ Email: _____

Home (sending) Institution: _____

Current Program: _____ PGY: _____

Rotation requested: _____

Program (clinical department) with whom rotation is requested: _____

☐ The REQUIRED Goals and objectives for requested rotation ARE attached.

Preferred rotation dates (mm/dd/yy to mm/dd/yy)

1st choice: _____ 2nd Choice: _____

[Please note that UFCOM-J must receive the completed request no less than 120 days before the anticipated start date. Also, a $25 non-refundable application fee is required for all applicants]

_____

Resident Signature Date

EXTERNAL RESIDENT'S PROGRAM DIRECTOR APPROVAL

My signature below indicates my approval of the resident request.

Program Director Name: _____

Address: _____

Phone: _____

E-Mail Address: _____

_____

Program Director Signature Date

Please send this completed and signed request form, check, and goals and objectives to:

UFCOM-J Office of Educational Affairs
653-1 West 8th Street
4th Floor, LRC Box L15
Jacksonville, FL 32209
904-244-3149
904-244-4771 Fax

Please call 904-244-3149 to make your $25 non-refundable application fee by check.