

HOSPITAL EXPERIENCE

(Please indicate clinical clerkships completed prior to date of rotation requested at Cleveland Clinic Florida)

Give full name and mailing address of the individual at your school who is to receive your evaluation and grade.

Name Title

Address City State Zip Code

E-mail Address: _____ Phone#: _____

What type of first year residency do you plan?

Are you aware of any limitation that would prevent you from performing the duties of the rotation for which you are applying?

No Yes If yes, please explain

All prerequisites must be met before you are approved for an elective rotation. [This includes the completion of ALL Core rotations and status as a final year medical student when you are scheduled to participate in the rotation.](#) A maximum of 2 elective rotations are approved per student. Only 2 absences are allowed per 4 week rotation and proof will need to be submitted. Please note that we have a 90 day prior written cancellation policy. If you need to cancel the rotation and is within the 90 days prior to starting the rotation, your school will be billed.

I certify that the information given on this form is true, accurate and complete.

Signature: _____ Date: _____
