THE UNIVERSITY OF CHICAGO
PRITZKER SCHOOL OF MEDICINE

Biological Sciences Learning Center
924 East 57th Street, Suite 104
Chicago, IL 60637
pritzker.uchicago.edu

AWAY ROTATION APPLICATION

This form must be completed and submitted for approval at least **two weeks prior** to beginning the away rotation in order to receive credit.

Approval of the away rotation and number of credits anticipated will be communicated to you via e-mail prior to the start date of the rotation.

Please return completed forms to:
Jill Kelly
BSLC 104S
jkelly@bsd.uchicago.edu
773.702.0290 (phone)
773.702.2598 (fax)

CONTACT INFORMATION & CHECKLIST

Name:_____

Student ID:_____

UChicago Email:_____

Pager:_____

Cell Phone:_____

Is your elective taking place at a LCME accredited medical school?

Yes ☐ No ☐

*Please note if your elective is taking place at an international location, you must fill out the PSOM International Student Experience Checklist.

- ☐ Away Rotation Acceptance Letter *(Please Attach)*
- ☐ Official Description of the Rotation from the Outside Institution *(Please Attach)*
- ☐ Signature of Either your Career Advisor or your Faculty Advisor *(Please Attach)*
- ☐ Forward the "Institutional Evaluation Form" to the Person Evaluating your Performance during the Away Rotation. It May Be Returned to Maureen Okonski via Fax to 773.834.1920 or mokonski@bsd.uchicago.edu

INSTITUTION INFORMATION

Institution Name:_____

Institution Address:_____

City:_____ State:_____ Zip Code:_____ Country:_____

Rotation Director/Supervisor Contact Name:_____

Title:_____ Date of Elective From:_____ To _____

Phone:_____ Email:_____

Course Number to Appear on Your Transcript:

☐	ANCC	32800	Anesthesiology		
☐	EMED	35000	Emergency Medicine		
☐	FMED	50200	Family Medicine		
☐	MEDC	73700	Medicine		
☐	NURL	46200	Neurology		
☐	OBGY	44400	Ob/Gyn		
☐	OPTH	48600	Ophthalmology		
☐	ORTH	40000	Orthopaedics		
☐	PATH	50000	Pathology		
☐	PEDS	32000	Pediatrics		
☐	PSCR	46800	Psychiatry		
☐	RADI	42900	Radiology		
☐	SURG	31200	Surgery		
☐	RCON	42900	Radiation Oncology		

Department or Sub-Specialty

Type of Credit Requested:

- ☐ Sub-Internship
- ☐ Clinical Clerkship
- ☐ Research
- ☐ Other Project

ADVISOR APPROVAL

Career/Faculty Advisor's Name:_____ Signature:_____

Department:_____ Date:_____

STUDENT STATEMENT & CHECKLIST CERTIFICATION

I, _____, certify that the above statements are true and correct.

Signature:_____ Date:_____

If you have any questions, please contact Maureen Okonski (mokonski@bsd.uchicago.edu).

PRITZKER SCHOOL OF MEDICINE OFFICE USE – Date Received:_____ Date Processed:_____
Units: _____ (*Will Be Assigned by the PSOM*)