



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 Michael McGinty via Fax to 773.834.1920 or mmcginty@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:		Department or Sub-Specialty	Type of Credit Requested:
<input type="checkbox"/> ANCC 32800 Anesthesiology	<input type="checkbox"/>	ORTH 40000 Orthopaedics	<input type="checkbox"/> Sub-Internship
<input type="checkbox"/> EMED 35000 Emergency Medicine	<input type="checkbox"/>	PATH 50000 Pathology	<input type="checkbox"/> Clinical Clerkship
<input type="checkbox"/> FMED 50200 Family Medicine	<input type="checkbox"/>	PEDS 32000 Pediatrics	<input type="checkbox"/> Research
<input type="checkbox"/> MEDC 73700 Medicine	<input type="checkbox"/>	PSCR 46800 Psychiatry	<input type="checkbox"/> Other Project
<input type="checkbox"/> NURL 46200 Neurology	<input type="checkbox"/>	RADI 42900 Radiology	
<input type="checkbox"/> OBGY 44400 Ob/Gyn	<input type="checkbox"/>	SURG 31200 Surgery	
<input type="checkbox"/> OPTH 48600 Ophthalmology	<input type="checkbox"/>	RCON 42900 Radiation Oncology	

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 Michael McGinty (mmcginty@bsd.uchicago.edu).

Pritzker School of Medicine Office Use	Date Received: _____	Date Processed: _____	
	Units: _____ <i>(Will Be Assigned by the PSOM)</i>		