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:

Michael McGinty
BSLC 104Q
mmcginty@bsd.uchicago.edu
(773) 834-1334
(773) 834-1920

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:

	Course	Number	Department or Sub-Specialty
☐	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

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

Pritzker School of Medicine Office Use – Date Received:______ Date Processed:______ Units:______ *(Will Be Assigned by the PSOM)*