



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 form to:

Michael McGinty
BSLC 104Q
mmcginty@uchicagomedicine.org
Fax: (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 email at mmcginty@uchicagomedicine.org

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"/>	OPHT 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: _____

