

Residency Rotation Change Form

This form MUST be completed at least 8 weeks prior to rotation. Failure to complete this form will result in the possibility of your request for rotation change not being granted. This form must be completed, signed and returned to the residency office. **Since your request may involve a change in costs to the hospitals, please contact the residency office for approval before attempting to get signature from the releasing attending physician.**

Resident Name: _____

Dates of Rotation to change: ____/____/____/to____/____/____

Rotation #: ____

Current Scheduled Rotation: _____

Requested Rotation: _____

Will this affect your clinic during this time? ____Yes ____No

If yes, list date(s) of clinics to be cancelled _____



***** Acceptance by Residency Office** _____ **Date** _____

Release Signature of Current Scheduled Rotation Attending _____ **Date** _____

Chief Resident Signature of Approval _____ **Date** _____

Program Administrator Signature of Approval _____ **Date** _____

Program Director Signature of Approval _____ **Date** _____

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- Changed on AMION _____
- Yearly rotation schedule _____
- Spreadsheet _____
- Faxed to attending _____
- Entered on New Innovations _____