ROCHESTER REGIONAL HEALTH

MEDICAL EDUCATION OFFICE
RIEDMAN CAMPUS
100 Kings Highway South, Suite 2300
Rochester, NY 14617
GraduateMedical.Education@rochesterregional.org

LECOM Rotation Request Form 22-23 Academic Year

Thank you for your interest in rotations with Rochester Regional Health! Complete this form in its entirety and send to GraduateMedical.Education@rochesterregional.org for review.

Full Name: ______________________________ Date: __________
Last *First* *M.I.*

Cell Phone: ____________________ Email: ______________________________

LECOM Campus: □ Bradenton □ Elmira □ Erie □ Seton Hill □ Other __________

Clinical Education Coordinator: ____________________

Clinical Core Campus: □ Rochester □ UMMC □ Other: __________

Current OMS: □ 1st Year Student □ 2nd Year Student □ 3rd Year Student □ 4th Year Student

Current Other Student Type: ____________________

Rotation Information

Rotation Type: ____________________ □ Core □ Elective □ Selective □ Senior Capstone □ Sub-I
Specialty

1st Preferred Time Slot: ____________________ 2nd Preferred Time Slot: ____________________

Indicate OMS Year At Time of Rotation: ____________________

Rotation Type: ____________________ □ Core □ Elective □ Selective □ Senior Capstone □ Sub-I
Specialty

1st Preferred Time Slot: ____________________ 2nd Preferred Time Slot: ____________________

Indicate OMS Year At Time of Rotation: ____________________

Rotation Type: ____________________ □ Core □ Elective □ Selective □ Senior Capstone □ Sub-I
Specialty

1st Preferred Time Slot: ____________________ 2nd Preferred Time Slot: ____________________

Indicate OMS Year At Time of Rotation: ____________________

Rotation Type: ____________________ □ Core □ Elective □ Selective □ Senior Capstone □ Sub-I
Specialty

1st Preferred Time Slot: ____________________ 2nd Preferred Time Slot: ____________________

Indicate OMS Year At Time of Rotation: ____________________

Additional Information

When requesting an Interventional Radiology Elective or Sub-I, student must affirm they are interested in applying to our Radiology Residency by checking yes below.

□ Yes, I affirm □ No, I do not affirm

I certify that the above information is correct to the best of my knowledge at the date of this request. I also understand that completing this form does not guarantee an offer of placement by Rochester Regional Health.

______________________________ ____________________
Signature Date