



**PHOENIX
CHILDREN'S
HOSPITAL**

APPLICATION FOR STUDENT ROTATION

1. Name _____
2. Address _____
3. City/State/Zip _____
4. Phone Day _____
5. Phone Evening _____
6. Email address _____
7. Medical School _____
8. Elective dates requested _____
9. Elective requested _____
10. *Letter from medical school stating approval of rotation enclosed? ___Y ___N
11. *Record of Immunizations enclosed? ___Y ___N
12. *Proof of liability coverage enclosed? ___Y ___N
13. *Proof of 3-4 week core pediatric inpatient rotation from an approved allopathic clerkship program or its equivalent enclosed? ___Y ___N
14. *Proof of 3-4 week core pediatric outpatient rotation from an approved allopathic clerkship program or its equivalent enclosed? ___Y ___N

* Rotation cannot be approved until all documentation has been received.

Please forward this form with above documentation to:

Courtney A. Albers
Department of Medical Education
Phoenix Children's Hospital
1919 E Thomas Rd.
Phoenix, AZ 85016
W. 602-546-0764
F. 602-546-0806

Rotation Request is ___approved ___denied

Comments _____