



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:

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

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Rotation Request is \_\_\_ approved \_\_\_ denied

Comments \_\_\_\_\_