**PRECEPTORSHIP and SPECIAL ROTATIONS**

**REQUEST FORM**

(MUST BE SUBMITTED 3 MONTHS PRIOR TO ROTATION)

NAME:

PGY LEVEL:

Describe elective request and goals of rotation:

List at LEAST 3 objectives for this rotation:

MONTH:

DATES:

(\*\*NOTE: This form MUST include a monthly calendar from the preceptor, which also identifies the percentage of ambulatory time during the rotation.)

PRECEPTOR/MENTOR INFORMATION:

NAME:

ADDRESS:

PHONE NUMBER:

I agree to supervise and evaluate the resident on the above detailed rotation.

Preceptor Signature

APPROVED: DENIED:

 DATE

Geoffrey Connors, M.D.

Program Director

Residency Training Program in Internal Medicine