



CLINICAL ROTATION REQUEST FORM

In order to schedule clinical rotations, the form needs to be submitted at least six (06) weeks prior to the requested start date. Students are required to have this document completed and submitted to the Clinical Rotation Coordinator of Greenheart Medical University, School of Medicine for clearance from The Bursar & Registrar's office.

STUDENT INFORMATION

Full Name: _____ Date: _____
 Address: _____
 Phone: _____ E-mail: _____

CLINICAL ROTATIONS REQUESTED

Rotation(s) Requested	No. of Weeks	Start Date	Core/Elective
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FILE STATUS & SUBMISSION OF DOCUMENTS

For all questions on Clinical Rotation slots & Scheduling please contact Clinical Coordinator. Please make sure that you have submitted all your documents & that your file is complete (Check all that apply)

- Official Transcript
 CV
 BMS Exit Exam
 Police Cert.
 Legal/Visa Status
 Immunization Records:
 MMR
 PPD (6 months)
 Chest X-Ray (PPD - 12 months)

Comments: _____

OFFICIAL SECTION

This is to CERIFY that the student is in GOOD STANDING with the GreenHeart Medical University and is hereby granted permission to be allowed into Clinical Training and be scheduled for the specified Clinical Rotations.

ACCOUNTING DEPT: Date Submitted: _____ Date Received: _____
BURSAR: Signature: X _____ Date: _____
REGISTRAR: Signature: X _____ Date: _____
DATES: Sent to Student: _____ Sent to Hospital: _____
NOTES: _____

CHECK ALL PROCESS SECTIONS & DOCUMENTS SUBMITTED:

- Financial Clearance
 Student File Documents
 Malpractice Insurance
 Good Standing Letter
 Setting Schedules Requested
 Scheduling Request to Hospital
 Data entry into SIS
 Payment to the Hospital/s
 Payment Invoice Numbers