Michigan State University College of Osteopathic Medicine
Clinical Clerkship Program
Non- Base Hospital Application for Clinical Clerkship Rotation

Please print legibly

Part I – To be completed by student (then fax to rotation site): **Date: _____**

Name: 3rd Year ☐ 4th year ☐

Address: Phone #:

Email Address: Base Hospital:

Application is made for a clerkship rotation in: *(name of service)*

Length of Training: *(# of weeks)* Beginning *(month/day/year)* Ending *(month/day/year)*

To be conducted at (check below):

☐ Hospital *(name)* or ☐ Office/ Clinic *(name)*_____

Hospital or Clinic Complete Address *(print legibly)*

Under the supervision of _____
(name of supervising physician or program coordinator)

List all CORE rotations completed prior to this rotation:

Part II – To be completed by physician/hospital (then fax to Clerkship):

Following documentation required prior to rotation: (*MSUCOM students automatically covered by malpractice)

☐ Ltr of Good Standing ☐ Malpractice certificate*

☐ Immunizations ☐ Other_____

Signature(s) confirm above student for service and dates indicated:

(Signature of Supervising Physician) *(Date)* *(Telephone Number)* *(Fax Number)*

(Signature of Director of Medical Education) Or other hospital/clinic/office representative) *(Date)* *(Telephone Number)* *(email)*

Return completed form to:
MSUCOM Office of the Registrar
965 Fee Road
C110 East Fee Hall
East Lansing MI 48824
517/353-7741 (Fax: 517/432-1976)
E-mail: hăúŝ2 a ŜŘwŜƎ@hc.Yˇădzº ŜŘdz

Clerkship Approval: _____ (initials)

Course #, Section, # credits, Semester:
_____

☐ Enrolled

NOTE: Student may not begin rotation until all required signatures are on file in the Office of the Registrar

Revised 4/10