



UCF COLLEGE OF MEDICINE CLERKSHIP/ELECTIVE CHANGE REQUEST FORM

This form must be submitted **at least 6 weeks prior** to the start of the rotation to be changed.
Submission of this request does not constitute approval.

Student Name: _____

PID: _____

Date of Submission: _____

ADD: Clerkship Number:	Rotation Dates:
Course Title:	
Location:	
DROP: Clerkship Number:	Rotation Dates:
Course Title:	
Location:	
Reason for Change:	

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I hereby acknowledge that I have discussed the above changes with my core specialty advisor,
Dr. _____. *(Please print name)*

Core Specialty Advisor Signature Approval: _____

Student Signature: _____

FOR OFFICE USE: APPROVED _____ PEOPLESFT _____ OASIS _____ STUDENT _____ DENIED _____
