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 Academy Leader, Dr. ______________________________. *(Please print name)*

Academy Leader Signature Approval: ____

Student Signature: ____

FOR OFFICE USE: APPROVED_______ PEOPLESOFT_______OASIS________STUDENT_____DENIED________