UCF College of Medicine

# M4 Clinical Independent Studies
# Home and Away Rotations

This form must be completed and approved 6 weeks prior to the rotation start date. Failure to do so may result in a "not for credit" elective month.

- You must complete all sections of this petition form & attachments and obtain all signatures before you will be registered for the course for credit. (You must be registered in order for liability coverage to be in effect.)
- No credit will be granted for work for which a student has been paid.
- Student may not be supervised by a parent or relative.

Student Name:_____ Date: _____

Rotation Start Date:_____ Rotation End Date: _____ Duration of Elective: _____4 Weeks ____2 Weeks

_____**Petition for HOME Clinical Rotation Credit (MDE 8900) (gold section)**
_____**Petition for AWAY Clinical Rotation Credit (MDX 8011) (blue section)**

**For HOME Rotation**, complete the following **and** attach a rotation description (examples of Away Rotation Sample Descriptions can be found on 4th year GPS)

Course/Elective Title:_____

Institution Name: _____

Address, City, State & Zip Code:_____

Institution Supervising Faculty or Contact Person:_____ _____

Supervising faculty or contact person email address:_____

Contact Telephone #:_____

Signature for Approval from Faculty:_____

**Initial that you understand and/or have completed each of the following for this HOME rotation:**

1. As part of this rotation/study I will not be rotating at a local hospital ____
   **or** as part of this rotation/study I will be rotating at one of the following:
   ____Nemours Children's Hospital ____UCF Health ____HCA Lake Nona Medical Center ____Lake Nona VA
2. I have confirmed that the supervising faculty is UCF COM affiliated and located in the State of Florida. _____
3. If you will be rotating at one of the above hospitals, please initial that you have reviewed the credentialing requirements found here:_____
4. I have discussed first day reporting instructions with the supervising physician, as well as any requirements expected to be completed by me prior to the first day of the rotation. _____

Student Signature:_____ Date:_____

Elective Director Signature or Student Affairs Dean:_____ Date:_____

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**For AWAY Rotation,** , complete the following **and** attach a rotation description (examples of Away Rotation Sample Descriptions can be found on 4th year GPS)

Course/Elective Title:_____

Away Institution Name:_____

Away Institution Address, City, State & Zip Code:_____

Away Institution Supervising Faculty or Contact Person:_____

Away Institution Supervising faculty or contact person email address:_____

Away Institution Contact Telephone #:_____

Away Institution Supervising Faculty Signature (NOTE: Applicable ONLY IF you are setting this rotation up directly with the supervising faculty and not through the host institution):_____

**Initial that you understand and/or have completed each of the following for the AWAY rotation:**

1. The supervising physician is a faculty member at an accredited medical school/residency program. (Note: if this is not satisfied, you may NOT complete the rotation. Credit will be denied.)_____
2. I understand that it is **my** responsibility to provide the supervising faculty with an evaluation form before the end of the rotation, and to provide them with instructions on submitting the form to the COM. _____
3. I have arranged for housing for the duration of the rotation._____
4. I understand that it is my responsibility to inquire if the host institution requires an affiliation agreement in advance and if applicable, contact Alisha Corsi, MD Registrar_____

Student Signature_____ Date:_____

Elective Director Signature or Student Affairs Dean:_____ Date:_____