Susquehanna Health
Williamsport Family Medicine Residency

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STUDENT ROTATION REQUEST FORM

DATE OF REQUEST: _____

NAME: _____

MAILING ADDRESS: _____

_____

TELEPHONE #: _____

E-MAIL ADDRESS: _____

****MEDICAL SCHOOL:** _____

GRADUATION YEAR: _____

CAREER PLANS: _____

ROTATION PREFERENCES: (Please rank 1st, 2nd, & 3rd Choice)

_____ **Family Medicine Inpatient**
_____ **Obstetrics**
_____ **Family Medicine Outpatient**
_____ **Pediatrics**

ROTATION DATES: (Please rank 1st, 2nd, & 3rd Choice)

_____ _____ _____

COMMENTS:

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****Due to regulations through the Pennsylvania State Board of Medicine, we are only able to offer rotations to students attending medical school in the United States.**

Please return to:

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Williamsport Family Medicine Residency
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