hsc THE UNIVERSITY of NORTH TEXAS HEALTH SCIENCE CENTER at FORT WORTH

Texas College of Osteopathic Medicine

Office of Osteopathic Clinical Education

ROTATION CANCELLATION

SECTION I: STUDENT CONFIRMATION

S/D Name ____________________ **Student ID #**________________________________ **Class of** ____________

Mobile Number ____________________ **Advisory College** ________________________

Period __________ **Exact Dates: From**____/____/______ **To** ____/____/______

Rotation Type: **Required EM** ❒ **Elective** ❒ **Non-credit Rotation** ❒

Clerkship____

Example: Pediatrics, Surgery, etc.

Site and/or Preceptor Name____

Student Signature ______________________________ **Date** ______________________________

SECTION II: SITE/PRECEPTOR CONFIRMATION

Please sign to acknowledge notification of cancellation.

Preceptor/Site Signature ____________________________________ **Date** ____________________

Phone__________________________________ **Email**____________________________________

SECTION III: DEPARTMENT CONFIRMATION (REQUIRED EM, ELECTIVES at HSC, and ELECTIVES SCHEDULED THROUGH CLINICAL EDUCATION ONLY)

Cancellation Request: **Approved** ❒ **Denied** ❒

Coordinator Signature__________________________________ **Date**____________________

**Signed by appropriate Clerkship/Elective Coordinator*

Please return this cancellation form via one of the following:

EMAIL: clinicaleducation@unthsc.edu **FAX: 855-574-0798**