



STUDENT ROTATION REQUEST FORM

DATE OF REQUEST: _____

NAME: _____

MAILING ADDRESS: _____

TELEPHONE #: _____

EMAIL 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:

****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:

Kristen Tubbs, Program Assistant
Williamsport Family Medicine Residency
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Williamsport, PA 17701
tubbskl@upmc.edu