POMONA VALLEY HOSPITAL
MEDICAL CENTER

Application for Rotation

Please submit this form and required documents via email to rotations@pvhmc.org.

Applicant/ Requestor

First Name: _____ Last Name: _____

Phone: _____ Email: _____

Street Address: _____ City: _____ Zip: _____

Emergency Contact:

Name: _____ Phone: _____

Current Education Level: ☐ Medical Student ☐ Resident/Fellow ☐ Other: _____

Current School/Program Name: _____

Degree Type/Program: _____

Current Education Level: ☐ Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4

Date range of experience: _____

Day(s) and Time(s): _____

Location of experience (Select One)

☐ PVHMC (Hospital): Department/Unit _____

☐ Other PVH Facility: Clinic/Location _____

What procedures and/or surgeries will be performed within the rotation? Please be specific.

_____

_____

_____

What are the preceptor's main teaching points for the rotation?

_____

_____

_____

What are the school's learning objectives for rotation?

_____

_____

_____

What interact and/or impact might this rotation have on other learners in the hospital?

_____

_____

_____

_____

Applicant Signature: _____ Date: _____

_____

Physician/ Healthcare Professional/ PVHMC Associate

First Name: _____Last Name: _____

Phone: _____Email: _____

☐ I approve the rotation request for the applicant above. I will provide necessary supervision and ensure applicant's compliance at all times.

Signature: _____ Date: _____

Medical/Clinic Director Approval

First Name: _____Last Name: _____

Phone: _____Email: _____

☐ I approve this rotation request.

Signature: _____ Date: _____