Student Rotation Request for Floyd

Individual submitting this request: ❑ Student ❑ Clinical Coordinator or other Program Representative		Please select type of request: ❑ New request ❑ Change to previous request
Student Name:	How would you like to be contacted: ❑ By Email ❑ By Phone	
Current Email: Preferred Phone:	Current Mailing Address: Street: City: State: Zip:	
School: Degree Program Name:		Graduation month/year:
Does your school currently have an Affiliation Agreement with Floyd Medical Center? ❑ YES ❑ NO		
Clinical Coordinator/ Program Contact:	Phone:	Email:

ROTATION PLACEMENT ASSISTANCE		
Dates of rotation	First day:	Last day:
Type of rotation (Ex. - Med Surg /Peds / etc)		
Do you need confirmation by a specific date?		❑ YES, I need to let my program know by: ________________ ❑ NO, I just need to know as soon as can be confirmed

**If you are an Instructor submitting this form for multiple students please attach rotation schedule that you would like to submit for approval.

Fax completed form to 866-521-1542.