Revised 12/02

Form H

REPORT OF CLINICAL ROTATIONS

APPLICANT'S NAME: _____ MEDICAL SCHOOL OF GRADUATION: _____

OTHER MEDICAL SCHOOLS ATTENDED: _____ SOCIAL SECURITY NUMBER: _____

PLEASE COMPLETE THIS REPORT OF CLINICAL ROTATIONS FORM WITH THE CORE CLINICAL ROTATIONS YOU DID WHILE IN MEDICAL SCHOOL. IF NOT COMPLETED, THE FORM WILL BE RETURNED WHICH COULD DELAY YOUR APPLICATION PROCESS.

***Please note that the 5 clinical core rotations will be verified for accreditation with the Accreditation Council for Graduate Medical Education (ACGME) for the time listed with the affiliated hospital. If we are unable to verify accreditation, you will be responsible for providing proof of accreditation before being able to qualify for Virginia Licensure.**

CLINICAL AREA	HOSPITAL NAME AND ADDRESS	DATES OF ATTENDANCE	WEEKS OF CREDIT	PROGRAM DIRECTOR
1. OB/GYN				
2. PEDIATRICS				
3. PSYCHIATRY				
4. MEDICINE				
5. SURGERY				
6. OTHER				

I HEREBY SWEAR THIS IS AN ACCURATE RECORD OF MY CLERKSHIPS.

_____

SIGNATURE DATE