USU Advanced Clinical Rotations / Sub-Internship
New Rotation Form

*** Students, please complete 1 through 8 ONLY ***

1. This course is being established for(Student name): _____

2. Title of Course
   Advanced Clinical Rotation: _____ or Sub-Internship: _____
   4 week duration 4 week duration
   Requested dates: _____ Block number: _____

3. Department: _____

4. USU Coordinator: _____

5. On-site Coordinator / GME: _____

6. Location / Address:
_____
_____

*Telephone number / e-mail address:
_____

7. General Objectives:
_____
_____

8. Description:
_____
_____

*****Coordinators please complete items 9 through 11*****

9. Grading: [ ] Pass/Fail (For all elective courses)
Grading Criteria (Attach a copy of any grading criteria given to students)

10. Catalogue: [ ] Yes, I wish to have this appear in the catalogue
[ ] No, I do not wish to have this appear in the catalogue

11. Approved: _____ Phone no.: _____
(Advanced Clinical Rotation / Sub-Internship director – sponsoring USU department)

Please return the completed form to:
Office of the Registrar, ATTN: Registrar, 4301 Jones Bridge Road, Bethesda, MD 20814-4799. Fax: (301) 295-3545 / E-mail: diana.romero@usuhs.edu