# RESIDENT REQUEST FOR AWAY ELECTIVE ROTATION

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| --- | --- |
| **DATE:** |  |
| **Resident Name:** |  |
| **Dates of Rotation:** |  |
| **Institution Name:** |  |
| **Address:** |  |
|  |  |
|  |  |
| **Rotation Type:** |  |
| **Program Director:** |  |
|  |  |
|  |  |
| **Address where rotations take place:** |  |
|  |  |
| **Coordinator’s Name** |  |
| **Telephone # and fax #** |  |
|  |  |
| **Chief Resident Approval (required for residencies):** |  |
| **Program Director Approval:** |  |
| **Associate DIO Approval:** |  |