



American University of the Caribbean

School of Medicine

Elective Request Form

Student Information

Full Name: _____

ID: _____

Phone: _____

Email: _____



The rotations on this form are Requested Only. This form does not confirm any of these elective rotations. Your Student Summary Sheet can be updated only after OCSA receives a written Confirmation from the hospital.

Hospital Information

Contact Person: _____

Email: _____

Hospital Name: _____

Mailing Address: _____
Street City State Zip Code

Rotation Name:	Rotation Dates:	
_____	From: MO/DD/YR	To: (MO/DD/YR)
_____	____ / ____ / ____	____ / ____ / ____
_____	____ / ____ / ____	____ / ____ / ____
_____	____ / ____ / ____	____ / ____ / ____
_____	____ / ____ / ____	____ / ____ / ____

Comments: _____

Please include any additional documents required to apply to for this elective rotation.

Elective requests may be received by e-mail, fax or regular mail at:

clinicalsaucmed.edu or OSCA Fax 786.228.3004

MEAS, Attn: OCSA/Elective Request, 901 Ponce de Leon Blvd., Ste. 700, Coral Gables, FL 33134

Note: Requests will not be considered unless all fields within the student and hospital information sections are completed. Scheduling elective rotations without using the elective request form is strictly prohibited and could cause problems with students' financial aid and licensure.