TEXAS TECH UNIVERSITY
Health Sciences Center
Paul L. Foster School of Medicine
Department of Internal Medicine

Rotation Schedule Change Request Form

Resident requesting rotation change: _____

Resident affected by this change: _____

Submission of this request doesn't guarantee approval. Request will be reviewed and a determination will be made based on all factors considered.

Proposed Rotation Change

Resident is requesting a change of rotation on (Month / Year) _____

From: _____ to _____

In an effort to make up for this change, resident is also requesting a change of rotation on

(Month / Year) _____ From: _____ to _____

Please see attached schedule for proposed changes affecting both residents.

Reason for change:

_____

_____

Justification: ___Educational ___Administrative ___Other_____

Potential Conflict Areas: ___Hospital ___Ambulatory ___Other_____

___ No Other Alternative available

___ Alternative Options:_____

Signature of resident requesting change Date	***Signature of resident accepting change Date***

Approval Signatures:

Chief Resident Jose Burgos, M.D.
Print or stamp name *Signature* *Date*

Chief Resident Hasan Salameh, M.D.
Print or stamp name *Signature* *Date*

Clinic Manager _____
Print or stamp name *Signature* *Date*

Attending Faculty _____
Print or stamp name *Signature* *Date*

Assoc. Prog. Dir. Tamis Bright, M.D.
Print or stamp name *Signature* *Date*

Program Director Pedro Blandon, M.D.
Print or stamp name *Signature* *Date*

7/9/09