DARTMOUTH MEDICAL SCHOOL
CLERKSHIP SCHEDULING / RESCHEDULE REQUEST FORM

(4 weeks prior to original begin date of clerkship):

Student Name: _____ Today's Date _____

Reason for your request: _____

_____

_____

_____

Clerkship:

Family Medicine	☐	**OB/GYN&WH**	☐
Medicine (inpt)	☐	**Pediatrics**	☐
Geriatric & Ambulatory Med	☐	**Psychiatry**	☐
Neurology	☐	**Surgery**	☐

Clerkship Director: _____

Clerkship Coordinator: _____

CLERKSHIP TO DROP FROM

Block & Track (1a, 1ab etc.)	Dates (mm/dd/yy) From	To
	/ /	/ /

CLERKSHIP RESCHEDULED TO or SCHEDULE TO
(Also for scheduling new clerkship or previously dropped clerkships)

Block & Track (1a, 1ab etc.)	Dates (mm/dd/yy) From	To
	/ /	- / /

Scheduled Site: _____ Requested Site: _____

To be completed by Clerkship and Clinical Education:

Date	Approved	Denied

_____
Signature of Clerkship (Director or Coordinator)

_____
Signature of Office of Clinical Education (Director or Dean)

Reason(s) for Denied Status:
☐ Requested block is full
☐ Insufficient time to provide accomodations
☐ Other (Please explain) _____

Requirements: Meet with Office of Clinical Education to formulate valid reschedule. Approval of Clinical Education and Clerkship required.

Student Directions:
☐ Formulate reschedule w/Clinical Education
☐ Complete unshaded sections.
☐ Forward completed form to clerkship.

☐ Spreadsheet _____ ☐ Banner Entry _____
☐ Database _____ ☐ Schedule to Student _____

Office of Clinical Education, HB 7015 (Rubin Bldg-Level 4)