Kansas College of Osteopathic Medicine
Clinical Education - OMS IV
Clinical Rotation Site Information Form

OMS IV Site Information (complete for each elective or sub-I)

Student Name: Date:

Elective Sub-I

Rotation Specialty: Course Number

Length of Rotation: *(# of weeks)* Beginning *(month/day/year)* Ending *(month/day/year)*

To be conducted at (check below):

☐ Hospital *(name)* or ☐ Office/ Clinic *(name)*____

Hospital or Clinic Information*:*

Site Contact Preceptor:

Address: Phone #:

Email Address:

Under the supervision of

(name of supervising physician or program coordinator)

(Signature of Supervising Physician and/or Site Contact). Only needed if outside of VSLO or Clinician Nexus. *Date*

Additional Information

Elective or Sub-I Obtained through:

VSLO Clinician Nexus Hospital/Clinic Website

Other

Please return form to KansasCOM OMS IV student if signature is required. OMS IV Student will be responsible to upload and submit to eValue 60 days prior to elective or sub internship start date. Please email or call Clinical Education if you have questions regarding this form. Clinicaleducation@kansashsc.org or (316) 315-5647.