TOURO UNIVERSITY
CALIFORNIA

Office of the Registrar ● 1310 Club Drive ● Vallejo, CA 94592 ● phone: 707-638-5984 ● fax: 707-638-5267 ● email: tucaregistrar@tu.edu ● website: http://tu.edu

College of Osteopathic Medicine: Doctor of Osteopathic Medicine
4th Year Rotations Consent Form

***Denotes Required Fields**

***NAME** (Please Print) ____________________ ***CLASS OF** ________ ***STUDENT ID#** ____________

COURSE NUMBER	COURSE NAME	UNITS
CLIN 819	Primary Care	6.0
CLIN 808-A	Medical Subspecialty 1	6.0
CLIN 808-B	Medical Subspecialty 2	6.0
CLIN 809	Surgical Subspecialty	6.0
CLIN 810	Acute Critical Care	6.0
CLIN 811	Emergency Medicine	6.0
CLIN 813-A[1]	4 week Elective Rotation	6.0
CLIN 813-B[1]	4 week Elective Rotation	6.0
CLIN 813-C[1]	4 week Elective Rotation	6.0
CLIN 813-D[1]	4 week Elective Rotation	6.0
	Total Units	**60.0**

1) Students may register into two 2 week Elective Rotations (CLIN 814 series) instead of a CLIN 813: 4 week Elective Rotation.

By signing below, I acknowledge that I must complete the curriculum above prior to being conferred my degree. Furthermore, I acknowledge that completion of this form does not constitute registration and that I must register for my clinical rotations every semester. Additionally, I consent to allow the Touro University California, College of Osteopathic Medicine: Clinical Education Department to update my registration with the Office of the Registrar.

***Student Signature** ________________________________ ***Date** ____________

For Office Use Only:

Date Received ____________