



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

3RD YEAR ROTATIONS CONSENT FORM

*Denotes Required Fields

*NAME (Please Print) _____ *CLASS OF _____ *STUDENT ID# _____

<u>COURSE NUMBER</u>	<u>COURSE NAME</u>	<u>UNITS</u>
CLIN 700-A	Internal Medicine 1	6.0
CLIN 700-B	Internal Medicine 2	6.0
CLIN 701-A	General Surgery 1	6.0
CLIN 701-B	General Surgery 2	6.0
CLIN 702-A	Family Medicine 1	6.0
CLIN 702-B	Family Medicine 2	6.0
CLIN 705	Psychiatry	6.0
CLIN 706 ¹	6 week OB/GYN	9.0
CLIN 707 ²	6 week Pediatrics	9.0
CLIN 716-A	4 week Elective Rotation	6.0
CLIN 716-B ³	4 week Elective Rotation	6.0
CLIN 770	Clinical Call Back	1.5

Total Units **73.5**

- 1) Students may register into CLIN 703: 4 wk OB/GYN & CLIN 714: 2 wk OB/GYN instead of CLIN 706.
- 2) Students may register into CLIN 704: 4 wk Pediatrics & CLIN 712: 2 wk Pediatrics instead of CLIN 707.
- 3) Students may register into CLIN 715-A: 2 week Elective Rotation & CLIN 715-B: 2 week Elective Rotation instead of CLIN 716-B.

By signing below, I acknowledge that I must complete the curriculum above prior to beginning my 4th year rotations. 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 _____