

FORM H REPORT OF CLINICAL ROTATIONS

Applicant's Name _____

Date of Birth: _____

Medical School of Graduation: _____

Other Medical Schools Attended: _____

COMPLETE THIS REPORT OF CLINICAL ROTATIONS FORM WITH THE CORE CLINICAL ROTATIONS YOU COMPLETED IN MEDICAL SCHOOL. IF THIS FORM IS NOT COMPLETED, IT WILL BE RETURNED WHICH COULD DELAY YOUR APPLICATION PROCESS.

Please note that if the 5 clinical core rotations were completed in the United States or Canada they will be verified for accreditation with the Accreditation Council for Graduate Medical Education (ACGME) for the time listed with the affiliated hospital. If the Board is unable to verify accreditation, you will be responsible for providing proof of accreditation before being able to qualify for Virginia licensure.

If you completed your rotations outside of the US you will not have an ACGME number.

If your rotations were completed over multiple occasions, you may print additional forms if needed.

Please refer to the application instructions for further information.

CLINICAL AREA	HOSPITAL NAME AND ADDRESS	DATES OF ATTENDANCE	WEEKS OF CREDIT	PROGRAM DIRECTOR	ACGME Accreditation #
1. OB/GYN					
2. PEDIATRICS					
3. PSYCHIATRY					
4. MEDICINE					

5. SURGERY					
6. OTHER					

I hereby swear this is an accurate record of my clerkships.

_____/_____
Signature Date