SCHOOL OF BIOMEDICAL SCIENCES

Rotation Approval Form

This form must be completed and filed prior to commencing each 7-week rotation.

Student Name: _____

Rotation Advisor Name: _____

Department: _____

Lab Location: _____ Kent State _____ NEOMED _____ Cleveland Clinic

Rotation: _____ 1st _____ 2nd _____ 3rd _____ 4th

Begin Date of Rotation: _____ End Date of Rotation: _____

_____ Date: _____
Student Signature

_____ Date: _____
Rotation Advisor Signature

If rotation is at NEOMED:

_____ Date: _____
Dr. Jeffrey Mellott

If rotation is at CCF:

_____ Date: _____
Dr. Jessica Williams

School of Biomedical Sciences

_____ Date: _____
Dr. John Johnson