

Department of Internal Medicine-Pediatrics
CALL SWITCH CHANGE FORM

Date Submitted: _____

Resident Requesting Change: _____ Rotation: _____

Resident Agreeing To Change: _____ Rotation: _____

<u>Clinic Date (& Site)</u>	<u>Resident Currently Assigned</u>	<u>Agreeing Resident</u>
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Clinic Day (& Site): _____

Reason for Change: _____

Requesting Resident Signature

Agreeing Resident Signature

For Chief Resident/Program Use

Approved

Clinic notified (initial and date): _____

Change made in AMION (initial and date): _____

Denied secondary to _____

Resident notified via _____ on (date) _____

Int-Med Program Director (Date)

Med-Peds Program Director (Date)

THIS FORM SHOULD BE FILLED OUT WHEN A CHANGE IS REQUESTED TO YOUR NORMAL CLINIC SCHEDULE DUE TO AN ABSENCE FROM CLINIC WITH LESS THAN 2 MONTHS NOTICE.

DO NOT ASSUME THAT ANY CHANGE IS MADE UNTIL YOUR REQUEST IS OFFICIALLY APPROVED. IF A CHANGE IS MADE AND THIS FORM HAS NOT BEEN SUBMITTED AND APPROVED, YOU WILL BE CONSIDERED ABSENT WITHOUT APPROVAL AND SUBJECT TO DISCIPLINARY ACTION BY THE PROGRAM.