

Clerkship Cancellation Form Handwritten and/or Incomplete Applications will not be accepted. Scanned PDF preferred.

SUBMISSION			
This form must be completed in its entirety and submitted to the GME Coordinator 30 days prior to the start of your scheduled clerkship.			
CONTACT INFORMATION			
Last Name	First	M.I.	
Name of School/Program		Email	
Phone	Mobile Phone		
DATES REQUESTED			
Specialty	Start Date	End Date	
NAME OF PRECEPTOR			
Last Name	First	<input type="checkbox"/> MD	<input type="checkbox"/> DO
ACKNOWLEDGEMENT			
My signature below confirms that I have requested to cancel my scheduled clerkship with Florida Hospital. I have notified my program of this change.			
This form will not be accepted without a signature from a representative from your institution. The Preceptor and/or department will be notified of this request. The completed form will be filed in the office of Graduate Medical Education.			
Print Name			
Signature, Student			Date
NAME OF SCHOOL/PROGRAM REPRESENTATIVE			
Print Name			
Signature, Representative			Date
CANCELLATION STATUS (FOR GME ADMINISTRATIVE USE ONLY)			
Date Cancellation Form Received		Date	
Coordinator/Preceptor Notified		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Signature, Florida Hospital Representative			Date

Submit Documentation to: Florida Hospital Graduate Medical Education

Attention: GME Clerkship Coordinator
 2501 North Orange Avenue, Suite 235 Orlando, Florida 32804
 E-mail: FH.GME.CLERKSHIP@flhosp.org
 Fax: 407.303.7323