UNIVERISTY OF MINNESOTA
Medical School

Ambulatory Care for Physician Scientists Registration
INMD 7540 and INMD 7541

Name ____Student ID #_____________

Term/Yr _______________________ Credits/Hours____________ Course #_____________

Supervising Physician _____________________________ Phone #____________________

MD/PhD Program Approval _______________________________ Date _________________

Start/End Date of Rotation ________________ Location ___________________________

Provide a Brief Summary Including Expectations for Completion of this Rotation
(attach additional pages if necessary)

Signature of Supervising Physician ______________________________Date __________

Signature of MD/PhD Student ________________________________Date ___________