



جامعة الملك عبد العزيز  
كلية الطب بربيع  
وحدة شئون أطباء الأمتياز



Appendix 2

**REQUEST FOR CHANGE OF ROTATION**

Name: \_\_\_\_\_ Mobile No: \_\_\_\_\_

ROTATION to change	MONTH	HOSPITAL	REQUESTED NEW ROTATION

**Reason why you would like to change &/or Cancel your rotation:**

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Acknowledge by: \_\_\_\_\_  
(Intern's Signature)

APPROVED BY : \_\_\_\_\_

DR. MOHAMMED FAROUQ  
Vice Dean Clinical Affairs