

**Elective Rotation in Public Health
Grant Request**

Submit completed form to:

Ernest Jacquez, Program Director
Texas Higher Education Coordinating Board
Division of Academic and Health Affairs
FamilyPractice@highered.Texas.gov

- 1. Family Medicine Residency Program: _____
- 2. Date of request _____
- 3. Name of resident _____
- 4. Name of supervisor _____
- 5. Rotation site _____
- 6. Rotation dates _____ to _____

(Resident must complete a full one-month rotation.)

7. A Public Health Rotation Grant is requested to cover the expenditures for a Public Health Rotation as follows:

- a. **Resident stipend** _____ \$500.00
- b. **Program expense** _____ \$1,500.00

8. **Total amount requested** _____ \$2,000.00

**The Evaluation Form for the Elective Rotation in Public Health
must be attached to this Form.**

Programs are to retain all receipts and documents for this rotation for four years.

9. I certify that the above expenditures were incurred as a result of a Public Health Rotation that meets Coordinating Board guidelines, and that all evaluations have been completed and returned to the appropriate persons.

Name of Program Director (Please Print)

Signature of Program Director