Elective Rotation in Public Health
Grant Request

Submit completed form to:

Suzanne Pickens, Senior Program Director
Texas Higher Education Coordinating Board
Division of Workforce, Academic Affairs and Research
FamilyPractice@THECB.state.tx.us

1. Family Medicine Residency Program:
   (name, phone, email address, fax)
   _____

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** _____

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