LONG BEACH MEDICAL CENTER
Caring for Life

Intern and Resident
Elective Rotation Attendance Form

Name of Resident: _____ Dates of Rotation _____

Rotation: _____ Date: _____

Date	Time in office	Signature of Attending	Signature of Office Manager

I hereby certify that the above named Intern/Resident was in attendance on the dates and times listed.

_____ _____

Attending Name and Signature Date