This form must be completed IN ADDITION to the rotation or mentor agreement form

NEW YORK STATE DEPARTMENT OF HEALTH SCHOOL OF PUBLIC HEALTH/

WADSWORTH CENTER STUDENT REASSIGNMENT

NAME: _____

AFFILIATION: School of Public Health

CURRENT LAB SUPERVISOR: _____

CURRENT ROOM ASSIGNMENT: _____

TELEPHONE: _____

FINAL DATE OF CURRENT LAB ASSIGNMENT: _____

NEW LAB SUPERVISOR: _____

NEW ROOM ASSIGNMENT: _____

NEW TELEPHONE: _____

EFFECTIVE START DATE OF NEW LAB ASSIGNMENT: _____

COMMENTS:

_____

_____

_____

PLEASE RETURN DIRECTLY TO SPH DEPARTMENT OFFICE CMS 2010