Application for a Non-Standard Off-Site Elective Rotation

Program Name: _____

Program Director Name: _____

Resident Name: _____

PGY Level _____ Pager _____ Phone _____

Section A. Rotation Information (to be completed by resident)

Institution Name: _____

Institution Address: _____

_____

Rotation Name: _____

Purpose of Rotation: _____

_____

Attach a copy of the educational goals and objectives for the rotation to this application

Proposed Rotation Dates: From _____ To _____

Length of Rotation: _____ weeks

Name of Supervising Physician: _____

Address: _____

_____

Phone Number _____ E-mail _____

Attach copy of written approval from elective site program director/supervising physician and central GME office

Outside Institution will provide professional liability coverage Yes _____ No _____

If yes, name of person contacted and phone number _____

_____

If no, name of malpractice insurance company where policy was purchased and phone number _____

_____

****Attach copy of the malpractice coverage certificate either from the institution or from the insurance company****

Resident Signature _____ Date _____

Section B. Program Director Review

Is this experience available at IFH? Yes _____ No _____

If yes, why is this rotation to be taken off-site? _____

_____

_____

Resident is in good academic standing Yes _____ No _____

Rotation Approved Yes _____ No _____

Reason for non-approval _____

_____

_____

_____

Program Director Signature _____ Date _____

Section C. Graduate Medical Education Director Review

Date Application Submitted _____

Rotation Approved Yes _____ No _____

Reason for non-approval _____

_____

_____

_____

GME Director Signature _____ Date _____