

Application for a Non-Standard Off-Site Elective Rotation

Program Name: _____
Resident Name: _____ PG Level _____
Program Director Name: _____ Beeper # _____
Phone # _____

Rotation Information (to be completed by resident)

Institution Name: _____
Institution Address: _____

Rotation Name: _____

Purpose of Rotation: _____

Proposed Rotation Dates: From _____ To _____

Length of Rotation _____ weeks

Name of Supervising Physician _____
Address _____

Phone # _____
email _____

Will institution provide professional liability coverage Yes _____ No _____
If no, name of person contacted and phone # _____

Is this experience available at YNHH or one of its affiliates? Yes _____ No _____
If yes, why is rotation to be taken off-site _____

Resident Signature _____ Date _____

For Completion by Program Director

Rotation Approved: Yes _____ No _____

Reason for non-approval _____

If experience can be obtained at Yale, why is there a need to take this rotation off-site?

Program Director Signature _____ Date _____

If approved, forward a copy of this form with the educational letter of agreement to the OGME-T-236

For Completion by Director, Graduate Medical Education

Rotation Approved: Yes _____ No _____

Reason for non-approval _____

Director, GME Signature _____ Date _____

For Completion by Risk Management Representative

Malpractice Coverage Approved Yes _____ No _____

Reason for non-approval _____

Notification of coverage sent to Institution _____ Date _____

Risk Management Signature _____ Date _____

When completed, return to Office of GME, Tompkins 236