THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF GRADUATE MEDICAL EDUCATION

REQUEST FOR ELECTIVE ROTATION
From a Non-JHU-Sponsored Program
To Suburban Hospital (SH)
(RESIDENTS AND CLINICAL FELLOWS)

This form should be completed for an outside elective rotation which is not part of the training program's standard rotations. The sponsoring program submits the completed form to the program contact for the Hopkins' department, who will then submit form to GMEOffice@jhmi.edu.

Period of Rotation: (Specific dates-mm/dd/yy)	From:		To:	

Sponsor Institution: (Name and full mailing address of location plus name and email address of contact person)	
Training Program:	
Training Program Director:	
Name of Rotator:	
Year in Training Program:	
Suburban Hospital Department:	
Suburban Hospital Preceptor:	

This rotation will: _____ Involve direct patient care _____ Involve observation only

1. Professional liability insurance (Minimum requirements: $1 Million per incident/$3 Million aggregate.):
will be provided by: _____Sponsor _____SH

If by Suburban Hospital, Certificate of Insurance shall be sent to:

_____

2. Salary and Fringe Benefit Payments to be made by: _____Sponsor _____SH

3. Reimbursements
_____There are no reimbursements to be made.
_____There is an agreement for reimbursement to be made between institutions; please attach a copy of the reimbursement agreement.

4. Suburban Hospital (SH) Responsibilities for the Rotation:

a. SH recognizes that the Program Director of the Sponsor's Program has the responsibility for the overall administration of the Training Program for the resident/clinical fellow.

b. The SH Preceptor shall evaluate the resident/clinical fellow upon completion of the rotation. (Does not apply for observation)

c. The SH Preceptor shall distribute to the resident/clinical fellow copies of SH policies, rules and regulations that will be applicable to the resident/clinical fellow.

d. The SH Preceptor will be responsible for coordinating and administering the rotation and will report all issues relating to the resident/clinical fellow to the Sponsor's Training Program Director.

e. The SH will provide to the resident/clinical fellow the equipment, resources, facilities and professional/technical/clerical personnel necessary for the rotation.

f. Any removal or discipline of the resident/clinical fellow by the SH will be discussed with the Sponsor's Training Program Director prior to action; provided, however, SH may take action when, in its opinion, the resident/clinical fellow pose an imminent threat to patient safety or welfare.

g. Pursuant to Section 952 of the Omnibus Reconciliation Act of 1980, Public Law No. 96-499 (the "Act"), the parties agree as follows: until the expiration of four years after the furnishing of the services provided under this Request, the parties will make available to the Secretary, U.S. Department of Health an Human Services, the U.S. Comptroller General, and their representatives, this Request and all books, documents, and records necessary to certify the nature and extent of the costs of those services. If a party carries out the duties of this Request through a subcontract worth $10,000 or more over a 12-month period with a related organization as defined in the Act, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General, and their representatives to the related organization's books and records.

5. Miscellaneous.

a. This Request shall be governed and construed according to the laws of the State of Maryland.

b. It is expressly understood that the parties hereto are independent contractors.

6. Overall Goal for this Rotation (attach additional page(s) if necessary). Complete the Objectives on page 3.

7. _____ A copy of the resident's/fellow's most recent ACGME milestones evaluation is attached. (OR - If rotation occurs prior to January of PGY1, program director has provided a letter attesting to the resident's skills for this rotation.)

_____ _____
Signature of Resident/Fellow requesting rotation Date

SUBURBAN HOSPITAL

_____ _____
Signature – SH Preceptor Date

_____
(Print Name)

SPONSOR INSTITUTION

_____ _____
Signature – Sponsor's Program Director Date

_____
(Print Name)

_____ _____
Signature – Sponsor's Official Date

_____
(Print Name)

Once the above signatures have been obtained, please send this form *WITH* the resident's/fellow's most recent ACGME milestones attached as one pdf to **GMEOffice@jhmi.edu**

GME Office use only:

_____ _____
Signature – Date
Jessica L. Bienstock, MD, MPH
DIO

_____ _____
Signature – Date
Jessica Melton, MHA
President and CEO

Please Note: DIO and President/CEO signatures to be obtained by GME office only

8. Objectives for this Rotation (please list at least one objective per ACGME Competency; attach additional page(s) if necessary). Every box in this chart needs to be filled.

List objective(s) under each competency heading	List the method for accomplishing the objective	List the evaluation method for assessing competence
Patient Care		
Medical Knowledge		
Practice-based learning and improvement		
Interpersonal and Communication Skills		
Professionalism		
Systems-based Practice		