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|  | **UNIVERSITY OF VIRGINIA HEALTH SYSTEM**  **AWAY ROTATION APPLICATION** | | |
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| **Form A: Required Rotation or Recurring Elective Rotation-INITIAL** | | | |
| **Type of Rotation1)** | | ( ) Required ( ) Elective |

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| 1. **General Information** | |
| **Program** |  |
| **Name and Location of Away Rotation Institution** |  |
| **Faculty/Physician Supervisor at the Rotation Institution** |  |
| **Type of Rotation1)** | ( ) Clinical only  ( ) Clinical and research combined  ( ) Non-clinical, research experience only |
| **Program Letter of Agreement2)** | ( ) Effective until (mm/dd/yy)  ( ) Not required for elective rotations |

*Note:* 1) A Curriculum Vitae of the faculty supervisor at the rotation institution with her/his specialty certification information must be provided if trainees engage in clinical activities. Faculty CV is not required for non-clinical, research only experiences. 2) Program must provide Program Letters of Agreement for a required rotation.

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| 1. **Information on Educational Values of the Rotation** |
| **Goals and objectives of rotation:** please specify how this rotation experience can enhance the education of the trainee. |
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| **Unique educational value of this rotation offers:** please explain unique educational values that the rotation offers. |
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| 1. **Program Director’s Acknowledgement** | | | |
| I endorse the unique educational values that this rotation offers in the education of the trainee and have approved the rotation for the trainees listed above. I am aware that adequate supervision of the trainee must be provided at the participating institution. I acknowledge that communication has been made with the faculty supervisor at the rotating site regarding the educational goals and objectives, supervision, and evaluation of the trainee during the rotation. By signing below, I am in agreement with the terms of this away rotation. | | | |
| **Signature of Program Director** |  | **Date** |  |

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| 1. **Review by the GME Education Subcommittee and GME Committee** | | | |
| **Checklist** | * Application signed by program director ( ) Yes ( ) No * CV of supervising faculty at the rotation institution attached ( ) Yes ( ) No * Letter of Agreement in place   ( ) Yes, valid until ( / / )  ( ) Not applicable | | |
| **Review Result** | ( ) Recommends approval to GMEC  ( ) Recommends approval to GMEC, pending \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ( ) Do not recommend approval to GMEC | | |
| **Signature of the Education Committee Chair** |  | **Date** |  |
| This rotation request was approved by the GMEC on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | |
|  | | **Date** |  |
| **Susan E. Kirk, M.D., DIO, Associate Dean for GME** | | | |