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|  | **UNIVERSITY OF VIRGINIA HEALTH SYSTEM**  **AWAY ROTATION APPLICATION** |
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| **Form C: One-time, Elective Rotation** | |

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| 1. **General Information** | | | |
| **Name of Trainee** |  | | |
| **Program** |  | | |
| **Year in the Program** |  | | |
| **Name and Location of Away Rotation Institution** |  | | |
| **Faculty/Physician Supervisor at the Rotation Institution** |  | | |
| **Type of Rotation\*** | ( ) Clinical only  ( ) Clinical and research combined  ( ) Non-clinical, research experience only | | |
| **Start Date of Rotation**  **(mm/dd/yyyy)** |  | **End Date of Rotation**  **(mm/dd/yyyy)** |  |

*Note:* 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.

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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. **Trainee’s Acknowledgement** | | | |
| **By signing below, I am in agreement with the terms of this away rotation**.  1.  I must notify my program director as soon as possible if any of the following events occur;           If any changes occur in rotation institution, schedule, or supervising faculty listed on this form;           If I am involved in a patient safety issue at my away rotation site;           If there is insufficient supervision or unsafe working conditions at my away rotation site.   1. I must seek immediate care by going to the Occupational Health or Emergency Department at my rotation institution in the event I sustain a workplace injury or exposure.  I must contact UVA’s Employee Health immediately (or on the next business day if exposure occurs after hours or on a weekend) by calling (434) 924-2013 to report the incident. 2. I am aware that I must submit a petition for exemption to the University of Virginia policies when my rotation site is in the country with the State Department’s Travel Warning. | | | |
| **Signature of Trainee** |  | **Date** |  |
| **Cell Phone** |  | | |

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| 1. **Program Director’s Acknowledgement** | | | |
| I endorse the unique educational value 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 institution regarding the educational goals and objectives, supervision, and evaluation of the trainee during this rotation.  I must notify the GME office immediately when the trainee 1) sustains workplace injury or exposure; 2) encounters insufficient supervision or unsafe working conditions; or 3) gets involved in patient safety issues at the rotation institution. 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 trainee  ( ) Application signed by program director  ( ) CV of supervising faculty at the rotation institution attached | | |
| **Review Result** | ( ) Recommends approval to GMEC  ( ) Recommends approval to GMEC, pending \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ( ) Do not recommend approval to GMEC | | |
| **Signature of the Committee Chair** |  | **Date** |  |
| This rotation request was approved by the GMEC on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | |
|  | | **Date** |  |
| **Susan E. Kirk, M.D., DIO, Associate Dean for GME** | | | |