UNIVERSITY OF VIRGINIA HEALTH SYSTEM
AWAY ROTATION APPLICATION

Form C: One-time, Elective Rotation

I. 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.

II. 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.
Unique educational value of this rotation offers: please explain unique educational values that the rotation offers.

III. 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.
2. 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.
3. 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			

IV. 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**	

V. 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	

Monica G. Lawrence, M.D., DIO, Associate Dean for GME