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

REQUEST FOR ELECTIVE ROTATION
OUTSIDE OF TRAINING PROGRAM'S STANDARD ROTATIONS
(RESIDENTS AND CLINICAL FELLOWS)

This form should be completed for each outside elective rotation which is not part of the training program's standard rotations. THIS FORM MUST BE TYPED.

The completed form must be signed by the resident/clinical fellow, the JHU Program Director, and the representatives at the Host Institution, and sent with the required documentation to GMEOffice@jhmi.edu for final approval by the Sr. Associate Dean for Graduate Medical Education / DIO.

Host Institution: (Name and full mailing address of location)		
Specialty Rotation at Host Institution:		
Preceptor at Host Institution and preceptor's email address and phone number:		
Period of Rotation: (Specific dates-mm/dd/yy)	From:	To:
Name of Hopkins Resident/Clinical Fellow:		
Johns Hopkins Department:		
Johns Hopkins Program Director:		
Year in Johns Hopkins Training Program:		

For out-of-state rotations, provide evidence that the appropriate out-of-state licensure has been obtained.
_____ Attached _____ Not applicable

Indicate the responsible institution for the following:
1. Professional liability insurance (Minimum requirements: $1 Million per incident/$3 Million aggregate): will be provided by:
_____Johns Hopkins _____Host Institution
* If provided by Johns Hopkins, Certificate of Insurance shall be sent to: (provide mailing address, e-mail and phone number)

2. Salary and Fringe Benefit Payments to be made by: _____Johns Hopkins _____Host Institution

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. Research Performed During Rotation:
If the resident or fellow participates in a research project during the course of the elective, this work will require approval from the Host Institution's Institutional Review Board.

_____ I, _____(resident/fellow name) understand that I must comply with the Host Institution requirements for Institutional Review Board approval. I also understand that, if any research I do at the Host Institution extends beyond the length of this elective rotation, I must submit a request to the JHM IRB to either have the JHM IRB review the research or to request an IRB Reliance Agreement.
_____ I will not be participating in any research project during my elective.

5. Host Institution Responsibilities for Rotation:

a. Host Institution recognizes that the Program Director of the Johns Hopkins Training Program has the responsibility for the overall administration of the Training Program for the resident/clinical fellow.

b. The Host Institution Preceptor will evaluate the resident/clinical fellow upon completion of the rotation.

c. The Host Institution will distribute to the resident/clinical fellow copies of Host Institution's policies, rules and regulations that will be applicable to the resident/clinical fellow.

d. The Host Institution Preceptor will be responsible for coordinating and administering the rotation and will report all issues relating to the resident/clinical fellow to the Johns Hopkins Training Program Director.

e. The Host Institution 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 Host Institution will be discussed with the Johns Hopkins Training Program Director prior to action; provided, however, Host Institution may take action when, in its opinion, the resident/clinical fellow pose an imminent threat to patient safety or welfare.

g. If the Host Institution is subject to accreditation by the Joint Commission or any other applicable accrediting agency, the Host Institution shall maintain such accreditation.

h. 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 and 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.

i. The Host Institution agrees to indemnify, defend and hold harmless Johns Hopkins University and its affiliates (and their respective employees, agents, trustees, officers and directors) (collectively, "Indemnitees") from and against any and all claims, losses, damages, suits, and costs (including attorneys' fees and defense costs), regardless of the outcome of such claims or actions, arising out of or relating to any allegedly negligent or intentional act or omission of the Host Institution, its officers, employees, or agents, including but not limited to, any violation or breach of duty owed to any third party, or any failure to perform any other covenant of this Agreement. The indemnification obligations herein shall not be limited by any insurance, or lack of insurance, maintained by the Host Institution. This indemnification provision shall survive termination or expiration of this Agreement.

6. 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.

7. Overall Goal for this Rotation; Complete specific goals & objectives on the next page.

_____Date_____
Signature – Resident/Clinical Fellow

THE JOHNS HOPKINS UNIVERSITY

_____Date_____
Signature – Training Program Director

_____
(Print Name)

_____ Date_____
Signature - Sr. Associate Dean for Graduate Medical Education and DIO
Jessica L. Bienstock, MD, MPH

HOST INSTITUTION

_____Date_____
Signature – Preceptor at Host Institution

_____
(Print Name)

_____Date_____
Signature – Official at Host Institution

_____
(Print Name and Title)

8. Objectives for this Rotation (please list at least one objective per ACGME Competency; attach additional page(s) if necessary)

Competency-based objective	Method for accomplishing the objective	Evaluation method for assessing competence
Patient Care		
Medical Knowledge		
Practice-based learning and improvement		
Interpersonal and Communication Skills		
Professionalism		
Systems-based Practice		

Elective Rotation – Addendum

Complete this form for any international elective rotation and attach to the Elective Rotation Request form.

Resident/Fellow Name: _____

Country of Travel: _____

In 250 words, or less, please describe how this international elective experience will provide a real and tangible impact to your career advancement, as well as why other options to accomplish this goal are not feasible.

_____

Resident/Fellow Signature

We have reviewed the above justification, discussed with the resident/fellow the risks and benefits to themselves of this experience, and support their request to participate in this international elective.

_____

Training Program Director Signature & Date

_____

Department Director Signature & Date