Resident Name:

GME POLICY #535  FORM - OFFSITE ROTATION APPROVAL

Please Note: Due to the impact of the COVID-19 Pandemic, all offsite rotations for our Residents and Fellows have been suspended as of April 2020. We will post on our website, the policy, and this form when the suspension is lifted and requests for these external rotations may resume. Thank you for your understanding.

Form – Offsite Rotation Approval

The purpose of offsite rotations is to meet training requirements that cannot be satisfied within University of Tennessee (UT) affiliated hospitals or clinical training sites. As with all Resident rotations, clear goals and objectives must be in place and Residents should receive mid-point performance feedback and a final written evaluation. Indicate if this request is for a rotation within the UT Statewide GME System.

If the offsite hospital is not able to reimburse for the Resident’s salary and benefits, a decision will need to be made regarding whether or not the Resident will need to waive compensation for the period of the rotation. A Waiver of Compensation Form must be signed by the Resident. If the Resident is not being paid during the rotation, or if the rotation is outside Tennessee, the Resident cannot be covered for malpractice by the State Claims Commission. The Resident will be responsible for obtaining and paying for personal malpractice insurance. UT is not able to pay for this personal malpractice protection.

Submission of the following documentation to the Office of Graduate Medical Education is required before requests will be presented to the DIO: 1) Request for Approval of Offsite Rotation; 2) Program Director Statement; 3) Waiver of Compensation Form (if appropriate); and 4) written goals and objectives.

Resident Name: ________________________________________
Program: ________________________________________
PGY Level: _____

Check here if this rotation will take place at a UTCOM Campus: ______

Name/Specialty of External Rotation:

External Sponsoring Institution name and address including names of all sites where the Resident may have contact with patients (practice sites, hospitals, etc.) during the rotation:

Dates of Rotation: From____________________ To_____________________

Describe the rationale for offering this rotation: ________________________________

Description of Resident activities:

Estimate % of the entire rotation that will be spent in external hospital(s): ______
Estimate % of the entire rotation that will be spent in a physician office: ______
Resident Name:

Check here if this is a UT Campus rotation since medical liability will be provided by the
Tennessee State Claims Commission: _____

The University of Tennessee under the provision of the Tennessee Claims Commission
Act cannot provide medical liability coverage for out of state rotations.

For rotations to non-UT affiliated hospitals, is malpractice provided by the host institution?

Yes _____ No _____ Not Applicable if a research or observing rotation ______

If the external institution is not providing malpractice coverage for an out-of-state rotation,
please attach a copy of the policy obtained and paid by the Residents.

Please return the completed forms at least 90 days prior to the start of the rotation to:

Office of Graduate Medical Education
960 East Third Street, Suite 104
Chattanooga, TN  37403

This portion should be completed by the UTCOM Chattanooga Associate Dean/DIO:

Rotation is: ___Approved   ___Denied

Resident will continue to be paid by UT: ___Yes   ___No

Resident has agreed to waive salary/compensation during the rotation: ___Yes   ___No

________________________________________  ______________________
Signature, UTCOM Chattanooga DIO            Date

This portion should be completed by the DIO or administrative official at the external
site:

Rotation is: ___Approved   ___Denied

________________________________________  ______________________
Signature, External DIO/Administrator        Date

Name and Title of above:
Approval from both Program Directors

As Program Director of the University of Tennessee Residency Training Program in the Department of ______________________________, I have reviewed this Offsite Resident Rotation Request with __________________________, Chair of the Department of ______________________________ (relevant department). We are in agreement that the training goals and objectives of this rotation cannot be satisfied within University of Tennessee (UT) affiliated hospitals or clinical training sites.

As with all Resident rotations, clear goals and objectives are in place for this offsite rotation. Those goals and objectives have been discussed and reviewed with ________________________ who holds the ______________________________ Faculty appointment rank of __________________________ at his or her institution and who will provide on-site supervision for this rotation. (Attach a copy of the rotation goals and objectives.)

UTCOM Chattanooga Approvals:

__________________________________________________________________________ Date
UTCOMC Program Director Signature
Program: ________________________________

__________________________________________________________________________ Date
UTCOMC Chair Signature

__________________________________________________________________________ Date
UTCOMC DIO Signature

__________________________________________________________________________ Date
UTCOMC Dean Signature

__________________________________________________________________________ Date
Erlanger CEO Signature

External Site Approvals:

__________________________________________________________________________ Date
External Program Director or Rotation Director Signature

Name of External Program Director or Rotation Director

__________________________________________________________________________
External DIO (if applicable) Signature
Program/Institution

Date
Resident Name:

Resident Waiver of Compensation (if applicable)

Name of Resident: ________________________________________________

Starting Date of External Rotation: ________________________________

Ending Date of External Rotation: ________________________________

Name of Rotation: ______________________________________________

Location of Rotation: ___________________________________________

Acknowledgement of Resident:

I understand that since the external rotation takes place at another hospital/institution, Erlanger will not be able to count my time toward its CMS GME reimbursement. Therefore, I am agreeable to waiving compensation from the University during the dates of the rotation. I am responsible for obtaining and paying for separate malpractice insurance to cover me for my patient care activities during the rotation.

I also agree to reimburse the University for the cost of my health/disability/life insurance premiums (employee and employer portion) at the end of each month during the rotation.

___________________________________________________________
Signature of Resident                                     Date

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Resident Name:

Name of Malpractice Carrier: ___________________________________________
(if applicable)

Policy #: ________________________________

If the external site provides malpractice protection or if, in the case of some international and medical missions trip, is not required, please attach a statement from the external site or sponsoring organization regarding this issue.

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Please attach a copy of the educational goals and objectives for this rotation and include approval noted by your Program Director.

:PDS