EMORY UNIVERSITY SCHOOL OF MEDICINE

Graduate Medical Education

Elective Rotations Application

Please submit 90 days in advance for processing

Instructions:
TO APPLICANT:

Please send your application to the Emory University ACGME Training Program **90 DAYS** prior to the requested start date of elective rotation.

Instructions:
TO EMORY PROGRAM COORDINATOR:

If the applicant has been accepted to do an elective rotation within your program, please send the Application/Authorization Form and Program Letter of Agreement (PLA) to the GME Office **90 DAYS** prior to the date the applicant begins his/her rotation. **Note: The application will NOT be accepted/processed without a reviewed and signed PLA.**

RESPONSIBILITY:

The GME Office responsibilities:

- Review/Process documentation
- Issue "Without Compensation" Contract
- Create data record in New Innovations
- Set Up Sponsored Account/ Request Emory Badge

Requesting Grady Access – **Grady Requires 60 days' notice for access:** Contact – gcoggins@gmh.edu

- Submit completed packets to the VA
- Notify EDH – **Requires 30 days' notice for access.**

The Program Coordinator responsibilities:

- Email completed Authorization Form and Program Letter of Agreement (PLA) to GME Office **90 DAYS** prior to rotation start date.
- Assist applicant with obtaining Georgia permit and express mail resident's permit application/check to GCMB *(GME can provide you a copy of the training permit application; however, GME **does not** need a copy of their permit application.)*
- Direct applicant to appropriate card office
  - Emory Card Office – B-Jones Building – Room 101 – 404-727-0224
  - Grady GME Manager's Office – Main Hospital Administration, 1st Floor, Room B107 –
    - 404-290-8252
- Request access for EeMR/Powerchart – Contact access coordinator within department
- Schedule CPOE training - eemrprovidertraining@emoryhealthcare.org
- Arrange parking ***(GME does not pay for parking)***
- Return performance evaluations to applicant's training institution.

EMORY UNIVERSITY SCHOOL OF MEDICINE

Graduate Medical Education

Authorization for Elective Rotations

Please submit <u>90 days</u> in advance for processing

HOME INSTITUTION:

Home Institution: ____

Visiting Resident Legal Name:___________________________________ Credentials (MD/DO)____________

PGY Level:________NPI#______________________DOB:_____________Email: ________________________

Requested ACGME Training Program: ____

Requested Dates of Rotation: FROM________________________TO ___________________________________

Program Coordinator:____________________________________Email: ________________________________

Have you rotated at Emory in the past? (Y/N) ________ Dates of last rotation (N/A) _________________________

Maiden/Previous Name during past rotation (N/A) ______________________________

TO BE SIGNED BY APPLICANT:

By applying for this temporary rotation to the House Staff at Emory University School of Medicine, I agree to abide by the rules and regulations of the hospital and service to which I am assigned. I understand that Emory will not provide a stipend, benefits, and professional liability insurance.

Signature of applicant:____Date: _________________

Printed name: ____

TO BE SIGNED BY HOME INSTITUTION PROGRAM DIRECTOR:

I approve the application of____*(visiting resident)*, who is currently enrolled as a PGY________resident/fellow in the Accreditation Council for Graduate Medical Education (ACGME) program,____(*specialty*) at ____ (*Name of Sponsoring Home Institution*) to rotate at Emory University School of Medicine. The Home Institution will continue to provide the stipend, benefits, and professional liability insurance.

Signature of Home Institution Program Director:_______________________________Date: _____________

Program Director Name (Print): ____

EMORY UNIVERSITY:

EMORY UNIVERSITY SCHOOL OF MEDICINE PROGRAM DIRECTOR APPROVAL:

I approve the elective rotation request for___________________________________*(visiting resident)* to participate in the above temporary rotation at________________________________*(Location Code)* for the dates specified, through the__________________________________program at Emory University School of Medicine. I confirm that this elective rotation will not dilute the educational experience of Emory residents.

Institution/Training Site	Location Code	Institution/Training Site	Location Code
Emory Hospital	**EUH**	Emory Orthopedic and Spine Hospital	**EOSH**
Emory Hospital Midtown	**EUHM**	The Emory Clinic	**TEC**
Emory St. Joseph's Hospital	**ESJH**	VA Medical Center	**VAMC**
Emory Johns Creek	**EJC**	Grady Hospital	**Grady**
Emory Decatur Hospital	**EDH**	CHOA-Egleston	**CHOA**
Emory Musculoskeletal Institute	**EMI**	CHOA-Scottish Rite	**CHOA**

SIGNED BY EMORY UNIVERSITY SCHOOL OF MEDICINE PROGRAM DIRECTOR:

Program Director:____Date: _____________________

Program Director Name (Print): ____

SIGNED BY EMORY UNIVERSITY SCHOOL OF MEDICINE CORE PROGRAM:

Program Director:____Date: _____________________

Program Director Name (Print): ____

Emory University Program Coordinator:

Name:________________________________Email:_____________________________Phone: ______________

☐ **Confirm:** Program Letter of Agreement and/or Master Agreement associated with rotation accompanies this authorization form.