



**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
- Request Grady Access - **Grady Requires 60 days notice for access – Contact – [gcoggins@gmh.edu](mailto: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
- 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
  - o **Emory Card Office** – B-Jones Building – Room 101 – 404-727-0224
  - o **Grady GME Manager’s Office** – Main Hospital Administration, 1<sup>st</sup> Floor, Room B107 –
    - 404-290-8252
- Request access for EeMR/Powerchart – Contact access coordinator within department
- Schedule CPOE training - [emrprovidertraining@emoryhealthcare.org](mailto:emrprovidertraining@emoryhealthcare.org)
- Arrange parking (**GME does not pay for parking**)
- Return performance evaluations to applicant’s training institution



**HOME INSTITUTION:**

Home Institution: \_\_\_\_\_

Visiting Resident Legal Name: \_\_\_\_\_ Maiden/Prev Name (N/A) \_\_\_\_\_

PGY Level: \_\_\_\_\_ NPI# \_\_\_\_\_ DOB: \_\_\_\_\_ Email: \_\_\_\_\_

Program Coordinator: \_\_\_\_\_ Email: \_\_\_\_\_

Requested ACGME Training Program: \_\_\_\_\_

Requested Dates of Rotation: FROM \_\_\_\_\_ TO \_\_\_\_\_

**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, in 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
Emory Hospital	EUH
Emory Hospital Midtown	EUHM
Emory St. Joseph's Hospital	ESJH
Emory Johns Creek	EJC
Emory Decatur Hospital	EDH
The Emory Clinic	TEC
VA Medical Center	VAMC
Grady Hospital	Grady
CHOA-Egleston	CHOA
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.