



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 30 days’ notice for access:** Contact – gme@gmh.edu

- Notify VA with completed packet through checklist
- Notify EDH – **Requires 30 days’ notice for access.**
- Notify ESJH and AMBH (CHOA) – **Requires 14 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. (*Direct applicant to the [GCMB website](#).*)
- 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 EPIC – 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.



Graduate Medical Education
Authorization for Elective Rotations
Please submit 90 days in advance for processing

HOME INSTITUTION:

Home Institution: _____

Full Legal Name: (L) _____ (F) _____ (M) _____ (MD/DO) _____

PGY Level: _____ NPI# _____ DOB: _____ Email: _____

Requested Emory Training Program: _____

Requested Dates of Rotation: FROM _____ TO _____

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

Maiden/Previous Name for last rotation (N/A) _____ Emory ID Card# (N/A) _____

Home Program Coordinator: _____ Email: _____

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) accredited 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:

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	AMBH – <i>formally</i> CHOA-Egleston	AMBH
Emory Musculoskeletal Institute	EMI	CHOA-Scottish Rite	CHOA

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 the location listed above is an official participating site for the Emory training program.

[] I confirm that this elective rotation will not dilute the educational experience of Emory residents.

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.