

ST. LUKE'S-ROOSEVELT HOSPITAL CENTER IN-ROTATION/ELECTIVE AUTHORIZATION FORM

PLEASE TYPE or PRINT CLEARLY

DEFINITIONS: Home—a resident primary training program (*Other Institution or Training Program*)

Host—SLRHC sponsored program

1. Home Training Program (*Other Institution*): _____

2. Is the Request for a/an: **Rotation:** Clinical _____ **Elective:** Clinical _____

Research _____ Research _____

(All in-rotators MUST complete the credentialing process prior to start date)

3. Resident/Fellow Name (s): _____ Training Level(s): _____

4. Name of Host Program Rotating Into (*Department Name*): _____

5. Is the Rotation/Elective/Research Required by the ACGME? Yes _____ No _____

6. Resident's Home Institution's Name: _____

Institution

Address:

City: _____ State: _____ Zip code: _____

a. Type of corporation: (i.e., not-for-profit, etc.) _____

b. Person authorized to sign an agreement: _____ d. Title: _____

c. Telephone Number: _____ e. Fax Number: _____

7. Is the Home Institution's Program Accredited (*Other training program*)? Yes _____ No _____

8. Detailed Description of Rotation: (Attach separate sheets, if necessary)

Include percentage of time the house officer will spend at the visiting institution (i.e., 100% or "only one day per week" or "4 half days per week") and whether the house officer will have any clinical responsibilities at his/her home institution during the dates of the rotation (i.e., Continuity time, Night Call, etc.)

9. Outline Educational Goals and Objectives of Rotation: (Attach separate sheets)

(Including rationale for experience - THIS INFORMATION IS **MANDATORY** IN ORDER TO PROCESS THIS FORM)

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10. Official Responsible for resident education and supervision (while on rotation): _____

11. Inclusive Dates of Rotation/Elective: From: _____ To: _____
(Month/Day/Year) (Month/Day/Year)

12. Length of Rotation/Elective: _____ days _____ months 13. Number of House officers: _____
(Total # of Days/)

14. Total FTE (s): _____ 15. PGY Level: _____
(# of days x # of residents divided by 365) (Current training level - this is MANDATORY)

16. Specify policies and procedures that will govern residents while on rotation: _____ SLRHC By-Laws,
_____ Host institution's

Home Program Director (Type/Print Name): _____

Home Program Director's Signature: _____
Date: _____

Home Department Chair (Type/Print Name): _____

Home Department Chair Signature: _____
Date: _____

Host Program Director (Type/Print Name): _____

Host Program Director's Signature: _____ Date: _____

Host Department Chair (Type/Print Name): _____

Host Department Chair Signature: _____ Date: _____

(PLEASE HAVE ALL PARTIES SIGN AND DATE THIS FORM BEFORE SUBMISSION TO SLRHC GME OFFICE)

For SLRHC GME Office Use Only

ST. LUKE'S-ROOSEVELT HOSPITAL CENTER **IN**-ROTATION/ELECTIVE AUTHORIZATION FORM

Approved: _____ Date: _____
Director, Graduate Medical Education

For SLRHC Finance Office Use Only

Approved: _____ Date: _____