Policy Statement

In general, all Resident and Fellow (hereinafter “Resident”) training experiences should be within facilities approved by the GME Office and listed as a Participating Institution on ACGME WebADS for the Morsani College of Medicine, while under the supervision of USF faculty.

Occasionally, and for brief periods, residents may be authorized to participate in extramural training experience in order to gain additional, specific educational opportunities.

Each experience must be approved individually by the Program Director and the Vice Dean for Graduate Medical Education. Such experience must have legitimate educational justification of intent and adequacy. Provision must be made for continuation of salary, benefits and assurance of professional liability coverage.

Procedure

The Resident must submits a written request for extramural rotation to the department (see attached Approval Form for Off-Site Rotations)

The Program Director verifies appropriateness of extramural rotation. The Education Coordinator ensures the Approval Form for Off-Site Rotations is accurate and sent to GME Office, including completion of PLA for the Institution/rotation providing the off-site rotation, as needed.

The GME Office ensures all information on the Approval Form is verified, including salary status and benefit continuation is verified. Office of GME also ensures information on rotation, duration, type of leave utilized, and salary & benefit coverage is accurately entered into New Innovations and appropriately mapped to a billing entity.

Office of GME ensures that Affiliation Agreement (as needed) is completed for the Institution / Location providing the off-site rotation experience, and obtains approval from Self Insurance and Vice Dean for GME on Approval Form.

APPROVED:

[Signature]
Vice Dean, Graduate Medical Education

APPROVAL FORM FOR OFF-SITE ROTATIONS

MUST BE RETURNED TO GME OFFICE THIRTY (30) DAYS PRIOR TO THE START OF OFF-SITE ROTATION

Resident Name: ____________________________, MD / DO  PGY Level: _____________

Current USF Residency Program: ________________________________________________

PHYSICAL Location of Off-Site rotation:

(Name) __________________________________________

(Address) ________________________________________

(City, ST, Zip) _____________________________________

(Phone) __________________________________________

Supervisor while at Rotation Site: ________________________________________________

START DATE: ___________________ END DATE: ___________________

Nature of Rotation / Assignment:  □ Patient Care  □ Didactics/Education  □ Research

RESIDENT/FELLOW SIGNATURE: _______________________________________________

NOTE: July 1, 2017, the cost of benefits (health, malpractice) for the Resident will be Department-funded, with each program having the option to charge the individual resident for his/her pro-rated benefit costs while on an off-site rotation.

===================================================================
PROGRAM:
Please indicate how Off-Site Rotation is being funded:

_____ Resident/Fellow taking unpaid Leave  _____ Resident/Fellow taking Vacation

_____ Paid By Off-Site Location*

*If checked, complete the New Rotation / Assignment Request Form (attached)

APPROVED:

PROGRAM DIRECTOR: __________________________________________ Date: _________

VICE DEAN, GME: __________________________________________ Date: _________

□ YES  □ NO  Covered under paid malpractice insurance; and is effective for the off-site location.

Note: International activities are only covered up to $200,000 per claim / $300,000 per occurrence. Physician bears responsibility over these amounts.

DIR., SELF INSURANCE PROGRAM: __________________________ Date: __________

Return Completed, Signed Letter of Approval (with Attachments) to:
Graduate Medical Education, MDC Box 41 or ptaylor@health.usf.edu

Revised 9/2017
UNIVERSITY OF SOUTH FLORIDA
GRADUATE MEDICAL EDUCATION
NEW ROTATION/ASSIGNMENT REQUEST FORM

Instructions: Programs complete the top section of this form for requesting a new rotation or assignment.

Program Name: ____________________________________________

Rotation/Assignment Name: __________________________________

Nature of Rotation/Assignment:
☐ Patient Care   ☐ Didactics   ☐ Research   Effective Start Date: ___ / ___ / ___

Explain % of time didactics and/or research, if applicable:

________________________________________________________________________

Description: _____________________________________________________________

________________________________________________________________________

PGY Level: _______________________________________________________________ 

Training Physical Location (name and address): ________________________________

________________________________________________________________________

Funding Source: __________________________________________________________

Funding Source FTEs:

________________________________________________________________________

SIGNATURE:

Program Director Name __________________________ Program Director Signature __________ Date __________

TO BE COMPLETED BY GME OFFICE
Select whether GME, IME or both are claimable for this rotation. ☐ GME   ☐ IME

Provider: _______________________________________________________________

GME Director Name ___________________________________ GME Director Signature __________ Date __________

Site/Funding Source Rep. Name __________________________ Site/Funding Source Rep. Signature __________ Date __________