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 30 days' notice for access:** Contact – medicaleducation@gmh.edu@gmh.edu

- Notify VA – **Requires Online process**
- 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 *(See Emory Card Office email)*
  - Grady Badge Office - near Pratt Street entrance to Grady Hospital __404.616.1908

- 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 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 – *formally* 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.