THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF GRADUATE CLINICAL EDUCATION

REQUEST FOR ELECTIVE ROTATION OUTSIDE OF TRAINING PROGRAM'S STANDARD ROTATIONS (ALLIED HEALTH TRAINEES)

This form should be completed for an outside elective rotation which is not part of the training program's standard rotations. The sponsoring program submits the completed form to the program contact for the Hopkins' department, who will then submit form to GCEOffice@jhmi.edu for final approval by the Director of Graduate Clinical Education.

Period of Rotation: (Specific dates-mm/dd/yy)	From:		To:	

Sponsor Institution: (Name and full mailing address of location plus name and email address of contact person)	
Training Program:	
Training Program Director:	
Name of Rotator:	
Year in Training Program:	
Howard County General Hospital Department:	
Howard County General Hospital Preceptor:	

This rotation will: ___◯___ Involve direct patient care ___◯___ Involve observation only

1. Professional liability insurance (Minimum requirements: $1 Million per incident/$3 Million aggregate.):
will be provided by: ___◯___Sponsor ___◯___HCGH

If by Johns Hopkins, Certificate of Insurance shall be sent to:

_____

2. Salary and Fringe Benefit Payments to be made by: ___◯___Sponsor ___◯___HCGH

3. Reimbursements
___◯___There are no reimbursements to be made.
___◯___There is an agreement for reimbursement to be made between institutions; please attach a copy of the reimbursement agreement.

4. HCGH Responsibilities for the Rotation:

a. HCGH recognizes that the Program Director of the Sponsor's Program has the responsibility for the overall administration of the Training Program for the resident/clinical fellow.

b. The HCGH Preceptor shall evaluate the resident/clinical fellow upon completion of the rotation. (Does not apply for observation)

c. The HCGH Preceptor shall distribute to the resident/clinical fellow copies of HCGH policies, rules and regulations that will be applicable to the resident/clinical fellow.

d. The HCGH Preceptor will be responsible for coordinating and administering the rotation and will report all issues relating to the resident/clinical fellow to the Sponsor's Training Program Director.

e. HCGH will provide to the resident/clinical fellow the equipment, resources, facilities and professional/technical/clerical personnel necessary for the rotation.

f. Any removal or discipline of the resident/clinical fellow by HCGH will be discussed with the Sponsor's Training Program Director prior to action; provided, however, HCGH may take action when, in its opinion, the resident/clinical fellow pose an imminent threat to patient safety or welfare.

g. Pursuant to Section 952 of the Omnibus Reconciliation Act of 1980, Public Law No. 96-499 (the "Act"), the parties agree as follows: until the expiration of four years after the furnishing of the services provided under this Request, the parties will make available to the Secretary, U.S. Department of Health an Human Services, the U.S. Comptroller General, and their representatives, this Request and all books, documents, and records necessary to certify the nature and extent of the costs of those services. If a party carries out the duties of this Request through a subcontract worth $10,000 or more over a 12-month period with a related organization as defined in the Act, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General, and their representatives to the related organization's books and records.

5. Miscellaneous.

a. This Request shall be governed and construed according to the laws of the State of Maryland.

b. It is expressly understood that the parties hereto are independent contractors.

6. Overall Goal for this Rotation (attach additional page(s) if necessary). Complete the Objectives on page 3.

7. ◯ A copy of the resident's/fellow's most recent evaluation is attached. (Does not apply for observation)

_____ _____
Signature of Resident/Fellow requesting rotation Date

HOWARD COUNTY GENERAL HOSPITAL

_____ _____
Signature – HCGH Preceptor Date

_____
(Print Name)

SPONSOR INSTITUTION

_____ _____
Signature – Sponsor's Program Director Date

_____
(Print Name)

_____ _____
Signature – Sponsor's Official Date

_____
(Print Name)

Once the above signatures have been obtained, please send this form *WITH* the resident's/fellow's most recent evaluation attached as one pdf to **GCEOffice@jhmi.edu**

GCE Office use only:

_____ _____
Signature – Date
Jessica L. Bienstock, MD, MPH
Director, Graduate Clinical Education

_____ _____
Signature – Date
Peter Hill, MD
Vice President for Medical Affairs

Please Note: Director and VP Medical Affairs signatures to be obtained by GCE office only

8. Objectives for this Rotation (please list at least one objective per ACGME Competency; attach additional page(s) if necessary)

Competency-based objective	Method for accomplishing the objective	Evaluation method for assessing competence
Patient Care		
Medical Knowledge		
Practice-based learning and improvement		
Interpersonal and Communication Skills		
Professionalism		
Systems-based Practice		