## THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE OFFICE OF GRADUATE MEDICAL EDUCATION

## REQUEST FOR ELECTIVE ROTATION From a Non-JHU-Sponsored Program To Sibley Memorial Hospital (SMH) (RESIDENTS AND CLINICAL FELLOWS)

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 GMEOffice@jhmi.edu.

Period of Rotation:	(Specific dates-mm/dd/yy)	From:		To:	
	(Name and full mailing address of and email address of contact person)				
Training Program:					
Training Program D	irector:				
Name of Rotator:					
Year in Training Pro	ogram:				
Sibley Memorial Ho	spital Department:				
Sibley Memorial Ho	ospital Preceptor:				
This rotation will: _	Involve direct patient care	Involv	re observation only		
1. Professional liability will be provided by	ry insurance (Minimum requirements: :: Sponsor SMH	\$1 Million per in	ncident/\$3 Million aggregate.):		
	Memorial Hospital, Certificate of Ins	surance shall be s	ent to:		
2. Salary and Fringe I	Benefit Payments to be made by:	Sponsor	SMH		
	reimbursements to be made. greement for reimbursement to be ma	de between instit	utions; please attach a copy of t	he reimbursement agreement.	
	ies for the Rotation: MH recognizes that the Program Directioning Program for the resident/clinic		sor's Program has the responsil	bility for the overall administrati	ion of the
b. T	The SMH Preceptor shall evaluate the resident/clinical fellow upon completion of the rotation. (Does not apply for observation)				

- - The SMH Preceptor shall distribute to the resident/clinical fellow copies of SMH policies, rules and regulations that will be c. applicable to the resident/clinical fellow.
  - d. The SMH 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.
  - The SMH will provide to the resident/clinical fellow the equipment, resources, facilities and professional/technical/clerical e. personnel necessary for the rotation.

- f. Any removal or discipline of the resident/clinical fellow by the SMH will be discussed with the Sponsor's Training Program Director prior to action; provided, however, SMH 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.

i. Miscellaneous. a. This Request shall be governed and construct	This Request shall be governed and construed according to the laws of the State of Maryland.				
b. It is expressly understood that the parties here	It is expressly understood that the parties hereto are independent contractors.				
5. Overall Goal for this Rotation (attach additional page(s) if nec	essary). Complete the Objectives on page 3.				
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orogram director has provided a letter attesting to the resident's sl	milestones evaluation is attached. (OR - If rotation occurs prior to January of PG kills for this rotation.)				
Signature of Resident/Fellow requesting rotation	Date				
SIBLEY MEMORIAL HOSPITAL	SPONSOR INSTITUTION				
Signature – SMH Preceptor Date	Signature – Sponsor's Program Director Date				
(Print Name)	(Print Name)				
	Signature – Sponsor's Official Date				
	(Print Name)				
	nd this form <u>WITH</u> the resident's/fellow's most recent ACGME milestones				
GME Office use only:	e pdf to GMEOffice@jhmi.edu				
Signature – Date Jessica L. Bienstock, MD, MPH	Signature – Date Hasan Zia, MD				
DIO  **Please Note: DIO and VP Medical Affairs signatures to be	President, Sibley Memorial Hospital				

8. Objectives for this Rotation (please list at least one objective per ACGME Competency; attach additional page(s) if necessary). Every box in this chart needs to be filled.					
List objective(s) under each competency heading	List the method for accomplishing the objective	List the evaluation method for assessing competence			
Patient Care					
Medical Knowledge					
Duratics hased learning and improvement					
Practice-based learning and improvement					
Interpersonal and Communication Skills					
personal and commenced simus					
Professionalism					
Systems-based Practice					
Systems-Dascu Fractice					