

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

**REQUEST FOR ELECTIVE ROTATION**  
**From a Non-JHU-Sponsored Program**  
**To Johns Hopkins Bayview Medical Center (JHBMC)**  
**(RESIDENTS AND CLINICAL FELLOWS)**

This form should be completed for each 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](mailto:GMEOffice@jhmi.edu).

Sponsor Institution: (Name and full mailing address of location plus name and email address of contact person)	
Training Program:	
Training Program Director:	

Period of Rotation: (Specific dates-mm/dd/yy)	From:		To:	
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Name of Rotator:	
Year in Training Program:	
JHBMC Department:	
JHBMC Preceptor:	

1. Attach a copy of the competency-based goals and objective for this rotation.
2. Professional liability insurance (Minimum requirements: \$1 Million per incident/\$3 Million aggregate.): will be provided by: \_\_\_\_\_ Sponsor \_\_\_\_\_ JHBMC  
If by Johns Hopkins, Certificate of Insurance shall be sent to:  
  
\_\_\_\_\_

3. Salary and Fringe Benefit Payments to be made by: \_\_\_\_\_ Sponsor \_\_\_\_\_ JHBMC

4. 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.

5. JHBMC Responsibilities for the Rotation:

- a. JHBMC 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 JHBMC Preceptor shall evaluate the resident/clinical fellow upon completion of the rotation.
- c. The JHBMC Preceptor shall distribute to the resident/clinical fellow copies of JHBMC policies, rules and regulations that will be applicable to the resident/clinical fellow.

- d. The JHBMC 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. The JHBMC 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 the JHBMC will be discussed with the Sponsor's Training Program Director prior to action; provided, however, JHBMC 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.

6. 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.

\_\_\_\_\_  
Signature – Resident/Fellow requesting rotation      Date

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

SPONSOR INSTITUTION

\_\_\_\_\_  
Signature – JHBMC Preceptor      Date

(Print Name)

\_\_\_\_\_  
Signature - Sponsor's Program Director      Date

(Print Name)

\_\_\_\_\_  
Signature – Renee Blanding, MD- Vice President of Medical Affairs      Date

\_\_\_\_\_  
Signature – Sponsor's Official      Date

(Print Name)

\_\_\_\_\_  
Signature – Jessica L. Bienstock, MD, MPH- DIO      Date