NOTE: Medicare regulations require the GME Office to provide detailed and accurate information on resident rotations, including research. This form and required documentation must be submitted to the GME Office by the Residency Coordinator no later than 90 days prior to the beginning of the research rotation. Forms submitted later than 90 days prior to the rotation will not be processed.

Name: PGY Level: Email Address:
GW Program:Time Period:
To Be Completed by Resident/Fellow
Brief Description:
Is research a requirement for your program? Is your research clinical or bench?
**Required Documentation: Educational rationale and Goals & Objectives for the rotation must be attached.
Is this research taking place at GW Yes No
Name & Address of Host Institution:
Name of Contact Person (administrator) at host institution:
Phone: Email address of Contact Person:
Resident/Fellow Signature Date
To Be Completed by Program Director
I approve this research elective and certify that the resident requesting this elective rotation is in good standing in the program. I have reviewed and approved the attached educational rationale and goals & objectives.
Approved by: Date: (Program Director)
(Program Director)
To Be Completed by Residency Coordinator
Is malpractice coverage required by the host institution? Yes No
Does the host institution require a Program Letter of Agreement (PLA)? Yes \Box No \Box
Name/title of physician site director at the host institution who has agreed to mentor the resident. This physician will be listed on the PLA as the site director.
Site Director
I certify that the above information is complete and accurate. I have contacted the host institution to determine if malpractice coverage and/or a PLA is needed. I have attached the PLA, and I have emailed the PLA (Word document) to the GME Director. I am submitting this form 90 days prior to the beginning of the rotation.
Signed: Date: Date:
(Residency Coordinator)
For GME/MFA Approval
GME Approval: Date: (Harold A. Frazier II, MD) **Dr. Frazier's signature is required for an away elective.
MFA Approval: Date: Date: (Anton Sidawy, MD) *Dr. Sidawy's signature is required for approval of malpractice coverage.