

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)

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 No

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: _____
(Residency Coordinator)

For GME/MFA Approval

GME Approval: _____ Date: _____
(Colleen N. Roche, MD) ****Dr. Roche's signature is required for an away elective.**

MFA Approval: _____ Date: _____
(Anton Sidawy, MD) ***Dr. Sidawy's signature is required for approval of malpractice coverage.**