GWU OFFICE OF GME - RESEARCH ROTATION FORM
for Research at GW or DC VA

NOTE: Use this form only if your research rotation will take place at GW or the DC VA and only if malpractice coverage and a PLA are not required. 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 30 days prior to the beginning of the research rotation. Forms submitted later than 30 days prior to the rotation will not be processed.

Name: _____ 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: Goals & Objectives for the rotation must be attached.

Is this research taking place at GWU? _____ DC VA? _____

_____ _____
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 VA? Yes ☐ No ☐

Name/title of physician site director at GW or the VA who has agreed to mentor the resident.

_____

I certify that the above information is complete and accurate. I have contacted the DC VA to determine if malpractice coverage is needed and to confirm that a PLA is not required for this rotation (90 days' notice is required for PLA processing). I am submitting this form 30 days prior to the beginning of the rotation.

Signed: _____ 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: _____
(Anton Sidawy, MD) ***Dr. Sidawy's signature is required if you need malpractice coverage.***

Rev. 08/2018