Saint Joseph Hospital AWAY ROTATION APPLICATION

Prior approval from the SJH GME office is required for all away rotations. Please complete Sections 1 and 2 and send to host facility for completion of Section 3. Once sections 1-3 are complete, please fax to GME Office at (303)318-3258, or deliver to Midtown Office Bldg., Suite 300

Incomplete applications will be returned to the resident!

SECTION 1: TO BE COMPLETED BY THE SJH RESIDENT:

NAME:_____________________________________________________

RESIDENCY PROGRAM:__________________________________ PGY LEVEL_______

Saint Joseph Hospital, Inc.
(303)318-3255
1375 E 19th Ave, Denver, CO 80218

ROTATION INFORMATION:

HOST SITE:________________________________ ROTATION NAME:_________________

SITE ADDRESS:_____________________________________________________________

ROTATION DATES FROM:_____-_____-_____ TO:_____-______-______(exact dates, please)

PRINT SUPERVISOR NAME:_____________________________ TITLE:__________________

The resident will be responsible for ensuring that patient care services are rendered in compliance with all pertinent provisions of federal and state law, subject to the oversight and general supervision of the rotation facility. The supervisor will be responsible for the resident’s teaching, supervision, and evaluation.

BRIEF DESCRIPTION AND GOALS AND OBJECTIVES OF ROTATION: The purpose of this rotation and affiliation is to:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

SECTION 2: TO BE COMPLETED BY THE RESIDENT’S PROGRAM DIRECTOR AT SJH:

I approve the rotation and the terms of this application.

_____________________________ ________________________ ____________________
Signature, Program Director  Print Name, Program Director Date Approved

SECTION 3: TO BE COMPLETED BY THE SUPERVISOR OR PROGRAM DIRECTOR OF HOST SITE:

I approve the above rotation during the specified dates. The appointment of the resident is subject to the by-laws of (name of facility resident is rotating) and its Medical Board and Medical Staff, as well as any rules and regulations promulgated under those by-laws. (My Institution) _______________________ will___, will not___ provide professional liability insurance for the resident for claims arising within the scope of the resident’s duties during the rotation. I agree to ensure that an evaluation is completed for this trainee.

______________________________ ___________________________ ___________________
Supervisor or Program Director  Print Name and Title   Date Approved

Host site is:  □Hospital  □ Nonhospital  □ Other _________________________________

SECTION 4: TO BE COMPLETED BY THE DESIGNATED INSTITUTIONAL OFFICIAL AT SJH

This rotation has been approved for the above dates. The resident will___, will not___ be covered by Preferred Professional Insurance Co. (through SJH) for claims arising within the scope of the resident’s duties during this rotation.

_____________________________
DIO/Chief of Academic Medicine Date Approved

Copy sent to resident

REVISED 2/2014