**UTCOMC GME POLICY #530 OFFSITE ROTATION APPROVAL PROCESS**

**Please Note**: ***Due to the impact of the COVID-19 Pandemic, all offsite rotations for our Residents and Fellows have been suspended as of April 2020, and only rotations at other UT System locations will be considered on a case by case basis. We will post on our website and this policy when the suspension is lifted and requests for other external rotations may resume. Thank you for your understanding.***

**Offsite Rotation Approval Process**

The purpose of offsite rotations is to meet training requirements that cannot be satisfied within University of Tennessee (UT) affiliated hospitals or clinical training sites. In order to avail itself of an offsite rotation opportunity, the requesting Resident\* and Program Director must first receive approval from the Associate Dean/Designated Institutional Official (DIO).

The Program Director is ultimately responsible for the ability of his or her program to meet ACGME and RRC requirements within UT facilities whenever possible. In the event that training requirements cannot be satisfied within facilities, completion of the following procedure is required before an offsite rotation may begin:

1) At least three months prior to the start of the requested offsite rotation, the Program Director will submit the following documentation to the Office of Graduate Medical Education (GME):

(a) Request for Approval of Offsite Rotation Form

(b) Program Director Statement

(c) Waiver of Compensation (if appropriate)

(d) Goals and Objectives for the rotation

2) Upon receipt of completed Request for Approval of Offsite Rotation Form and accompanying documentation, GME staff will present the request to the Offsite and DIO for approval.

3) The Director of GME or a GME staff member will send notice of approval of request to the Program Director when all approvals have been secured. Likewise, the Graduate Medical Education (GME) Department will send notice of denial to the Program Director if the request is denied.

4) The Program Director is responsible for ensuring that the Resident has completed and submitted a malpractice insurance application to a valid company for all offsite rotations as necessary. The UT Office of Risk Management in Knoxville can assist in finding a company that will provide a malpractice insurance policy to the Resident.

\*The term “Resident” refers to both Resident and Fellow trainees.

Revised and Approved by the GMEC 5/16/2017. Administrative edits made by the GME Director 6/17/2020.

**Form: Request for Approval of Offsite Rotation**

The purpose of offsite rotations is to meet training requirements that cannot be satisfied within University of Tennessee (UT) affiliated hospitals or clinical training sites. As with all Resident rotations, clear goals and objectives must be in place and Residents should receive mid-point performance feedback and a final written evaluation. Indicate if this request is for a rotation within the UT Statewide GME System.

If the offsite hospital is not able to reimburse for the Resident’s salary and benefits, a decision will need to be made regarding whether or not the Resident will need to waive compensation for the period of the rotation. A Waiver of Compensation Form must be signed by the Resident. If the Resident is not being paid during the rotation, or if the rotation is outside Tennessee, the Resident cannot be covered for malpractice by the State Claims Commission. The Resident will be responsible for obtaining and paying for personal malpractice insurance. UT is not able to pay for this personal malpractice protection.

Submission of the following documentation to the Office of Graduate Medical Education is required before requests will be presented to the DIO: 1) Request for Approval of Offsite Rotation; 2) Program Director Statement; 3) Waiver of Compensation Form (if appropriate); and 4) written goals and objectives.

Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PGY Level: \_\_\_\_\_

Check here if this rotation will take place at a UTCOM Campus: \_\_\_\_\_\_

Name/Specialty of External Rotation:

External Sponsoring Institution name and address including names of all sites where the Resident may have contact with patients (practice sites, hospitals, etc.) during the rotation:

Dates of Rotation: From\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the rationale for offering this rotation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Resident activities:

Estimate % of the entire rotation that will be spent in external hospital(s): \_\_\_\_\_\_

Estimate % of the entire rotation that will be spent in a physician office: \_\_\_\_\_\_\_

Check here if this is a UT Campus rotation since medical liability will be provided by the Tennessee State Claims Commission: \_\_\_\_\_

**The University of Tennessee under the provision of the Tennessee Claims Commission Act cannot provide medical liability coverage for out of state rotations**.

For rotations to non-UT affiliated hospitals, is malpractice provided by the host institution?

Yes \_\_\_\_\_ No \_\_\_\_\_ Not Applicable if a research or observing rotation \_\_\_\_\_\_\_

If the external institution is not providing malpractice coverage for an out-of-state rotation, please attach a copy of the policy obtained and paid by the Residents.

***Please return the completed forms at least 90 days prior to the start of the rotation to:***

Office of Graduate Medical Education

960 East Third Street, Suite 104

Chattanooga, TN 37403

**This portion should be completed by the UTCOM Chattanooga Associate Dean/DIO:**

Rotation is: \_\_\_Approved \_\_\_Denied

Resident will continue to be paid by UT: \_\_\_Yes \_\_\_No

Resident has agreed to waive salary/compensation during the rotation: \_\_\_Yes \_\_\_No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature, UTCOM Chattanooga DIO Date

**This portion should be completed by the DIO or administrative official at the external site:**

Rotation is: \_\_\_Approved \_\_\_Denied

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature, External DIO/Administrator Date

Name and Title of above:

**Approval from both Program Directors**

As Program Director of the University of Tennessee Residency Training Program in the Department of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I have reviewed this Offsite Resident Rotation Request with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Chair of the Department of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (relevant department). We are in agreement that the training goals and objectives of this rotation cannot be satisfied within University of Tennessee (UT) affiliated hospitals or clinical training sites.

As with all Resident rotations, clear goals and objectives are in place for this offsite rotation. Those goals and objectives have been discussed and reviewed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ who holds a Faculty appointment at the rank of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at his or her institution and who will provide on-site supervision for this rotation. (Attach a copy of the rotation goals and objectives.)

**UTCOM Chattanooga Approvals:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UTCOMC Program Director Signature Date

Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UTCOMC Chair Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UTCOMC DIO Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UTCOMC Dean Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Erlanger CEO Signature Date

**External Site Approvals:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

External Program Director or Rotation Director Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of External Program Director Program/Institution

or Rotation Director

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
External DIO (if applicable) Signature Date

**Resident Waiver of Compensation (if applicable)**

Name of Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Starting Date of External Rotation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ending Date of External Rotation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Rotation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Rotation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acknowledgement of Resident:

I understand that since the external rotation takes place at another hospital/institution, Erlanger will not be able to count my time toward its CMS GME reimbursement. Therefore, I am agreeable to waiving compensation from the University during the dates of the rotation. I am responsible for obtaining and paying for separate malpractice insurance to cover me for my patient care activities during the rotation.

I also agree to reimburse the University for the cost of my health/disability/life insurance premiums (employee and employer portion) at the end of each month during the rotation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Resident Date

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Name of Malpractice Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if applicable)

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the external site provides malpractice protection or if, in the case of some international and medical missions trip, is not required, please attach a statement from the external site or sponsoring organization regarding this issue.

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Please attach a copy of the educational goals and objectives for this rotation and include approval noted by your Program Director.

:PDS