

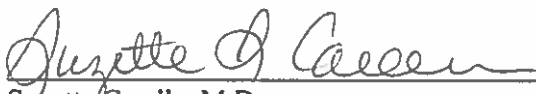
**CAROLINAS MEDICAL CENTER
GRADUATE MEDICAL EDUCATION
AWAY ROTATION POLICY
(DOMESTIC)**

Created: 1994

Reviewed: 8/01, 2/03, 7/03, 10/04, 1/07, 8/07, 12/12, 2/19

Revised: 3/95, 8/95, 2/97, 12/97, 10/08, 12/12, 2/19


1. **Definition:** The domestic away rotation are rotations which occur at any site within the United States **other than** an Atrium Health facility or practice.
2. A description of the proposed educational experience must be submitted by the Program Director **prior** to the rotation. ***Attachment I*** of this policy must be completed and signed by the Program Director.
3. The Designated Institutional Official (DIO) must sign ***Attachment I*** prior to sending to Corporate Risk Management for signature.
4. Prior to participating in a rotation, the following requirements must be met:
 - 1) Justify the need and prepare educational rationale describing this educational experience
 - 2) Review the Institutional requirements of the away rotation site
 - 3) ID the site director per ACGME requirements
 - 4) Confirm an Affiliation Agreement is in place (*if not, complete Attachment I, Affiliation Agreement section*)
 - 5) Prepare PLA including Goals and Objectives, *if applicable*
 - 6) Submit together the PLA and ***Attachment I*** of this policy for approval to the GME Office with a **minimum of a 90-day notice**
 - 7) Assure the site is included in Program's list of sites in MedHub
 - 8) Maintain PLA (must be renewed every 10 years)



Suzette Caudle, M.D.
ACGME Designated Institutional Official
Graduate Medical Education

2/15/2019

Date



Christopher Bowe
Interim President, Carolinas Medical Center
COO and Vice President of Operations, Central Division

2/20/19

Date



**AWAY ROTATION (DOMESTIC) REQUEST
FOR AFFILIATION AGREEMENT & ROTATION APPROVAL**

ATTACHMENT I

Please consider this a request to prepare a Clinical Education Affiliation Agreement

Atrium Health Coordinator and Program/Rotation for which application is being made:

Coordinator: _____ Program: _____

Residents Name: _____ PGY Level: _____

Start Date: _____ End Date: _____

Email Address: _____

Preceptor:

Name: _____ Title: _____

Phone: _____ Email: _____

Brief Description of Rotation: _____

AFFILIATION AGREEMENT - TO BE COMPLETED BY THE AWAY INSTITUTION:

*(*Only if an Affiliation Agreement is not in place)*

*Agreement be Auto Renewal: _____ Yes _____ No

*Away institution representative for any written communication or notice regarding Affiliation Agreement:

Name: _____ Title: _____

Address: _____

*Authorized official signing authority for away institution:

Name: _____

Title: _____

*Official legal name of away institution site to be used in Affiliation Agreement:

Name: _____

Address: _____

APPROVAL FROM ATRIUM HEALTH: (must be signed by PD before Affiliation Agreement is requested)

Program Director

Date

Designated Institutional Official (DIO)

Date

Corporate Risk Management

Date

RETURN COMPLETED FORM TO THE GME OFFICE