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

Atrium Health

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