1. PURPOSE

The purpose of this policy is to establish policy and procedure to ensure the quality of education and appropriate supervision for off-site elective rotations.

2. POLICY

IUSM residents may, with program director’s approval, participate in training programs outside of the affiliated hospital system. While it is within the program director’s discretion to allow electives, there should be appropriate justification to provide off-site rotations if the educational experience exists within the IUSM GME system. An application must be completed by the resident which includes a detailed description of the rotation’s goals, objectives and competency-based curriculum. (Attachment 1). Program directors must ensure that appropriate evaluations are completed for residents on away electives in order to document credit for the time spent away. There must be a program policy on how to apply for away rotations, amount of permissible away time and if necessary, procedure for the completion of missed core educational sessions.

Funding of salary, all fringe benefits will remain as fiscally approved by IUSM GME unless explicitly stated otherwise in the Affiliation Agreement. Professional liability coverage should be provided by the accepted institution, if possible.

IUSM GME is not responsible for any subsidization for housing, meals, or parking for residents while on away rotations. This must be communicated to the rotating resident by the Division or Department prior to the initiation of the away rotation request.

If a resident is training with an H-1B visa, a consultation with the Office of International Affairs is required to determine any special additional costs and restrictions.

3. SCOPE

This policy applies to all Indiana University School of Medicine (IUSM) GME resident and fellow physicians.

4. DEFINITIONS

4.1 A resident is an IUSM resident or fellow, or a non-IUSM resident or fellow electively rotating through IUSM and providing clinical care as part of a GME program.

4.2 Rotation assignments, when performed outside the system, are referred to as “elective rotations.”
5. **PROCEDURE**

Guidelines for requesting and approving an off-site elective rotation are:

A. Residents must complete the Elective Request Packet (Attachment 1) and obtain the permission and signature of the program director. This paperwork must be submitted to the IUSM GME Office a minimum of 60 days prior to the time of the requested elective. This allows time for processing and execution of an affiliation agreement. An additional form is required for international rotations and includes emergency information and travel information. (Attachment 2) Residents must complete the release from liability form related to U.S. State Department Travel Warning (Attachment 3). This form can be modified and completed for all international travel.

B. In order to complete your application, you must include a letter of acceptance or signed Program letter of Agreement from the supervising physician to your program director that includes:
   a. Detailed description of the rotation (including amount of time and summary of clinical and/or research responsibilities)
   b. Whether the experience is in an ACGME accredited program
   c. Educational goals and objectives of the rotation
   d. Official responsible for resident education and supervision
   e. Inclusive dates of the rotation
   f. Agreement for the supervisor and resident to complete an end of elective evaluation form. Failure to complete an evaluation will result in no credit.

C. It is the responsibility of the program director and coordinator to communicate with the Graduate Medical Education Office in order to create an affiliation agreement with the elective institution, and to ensure that accreditation standards including supervision, working hours, and safety are followed.

6. **IMPLEMENTATION**

The Designated Institutional Official (DIO) for Graduate Medical Education is responsible for implementation of this policy.

7. **OVERSIGHT**

Policy authority for this document resides with the Graduate Medical Education Committee. The DIO and the Graduate Medical Education Committee are responsible for oversight. This policy will be reviewed every three years or more often if deemed necessary.

8. **References**

1. ECFMG Required Notification for Off-Site Elective


2. 
9. ATTACHMENTS

1. Graduate Medical Education Elective Request Packet
2. Graduate Medical Education International Rotations Contact Information Form
3. Assumption of Risk and Release From Liability
Elective Request Packet
AWAY ELECTIVE ROTATION APPROVAL PROCEDURE FORM

Name ___________________________ Program ___________________________

Elective ____________________________ Month ___________________________

GME Name Contact information at Elective Site ____________________________________________
(this is required to determine if affiliation agreement is needed, etc.)

Two Months before Elective

Is this an AWAY rotation? □ yes □ no

If Yes:
□ Complete form 60 days prior to rotation
□ Leave request must be completed and attached to form (if applicable)

Goals and Objectives defined with Faculty Advisor and attached to form
Rotation Calendar attached to form (with clinic days, didactics, vacation, etc.)
Rotation Supervisor ____________________________

Faculty Advisor Signature ____________________________ Date __________

Elective Packet submitted to Coordinator (insert name) __________ Date __________
Reviewed by Program Director (insert name) ________________ Date __________

Return packet to Program Coordinator after obtaining program leadership signatures
(Copy of packet should be sent to GME Office @ Houstaff@iupui.edu)
# Elective Rotation Request

*Must be completed 60 days in advance of planned start of requested rotation*

<table>
<thead>
<tr>
<th>Resident’s Name</th>
<th>Today’s Date</th>
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<tbody>
<tr>
<td>PGY Level</td>
<td>Block of Requested Rotation</td>
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<td>Elective Requested</td>
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<td>Location of Elective</td>
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<td>Preceptor/Supervisor</td>
<td>Preceptor/Supervisor’s Phone #</td>
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<td>Preceptor/Supervisor’s Address</td>
<td>Preceptor’s E-Mail:</td>
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<tr>
<td>Address where you can be reached</td>
<td>Phone # where you can be reached</td>
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<td>Goals (or attach separate page)</td>
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Attach completed calendar detailing your activities for the month (include didactic time) to Elective Packet.

Approval:

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**Faculty Advisor**  ____________  **Residency Director**  ____________  **Date**  ____________  **Date**  ____________
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Attachment 2

Graduate Medical Education

International Rotations Contact Information Form

Contact Information for International Rotations

The following document must be submitted along with a copy of your flight itinerary prior to travel or participation in the program will be defaulted.

Rotation dates ____________________ to __________________

Resident Information

Name (Last, First) ________________________________ Dates in [country] __________________

Passport Number __________________ Place of Birth __________________ Date of Birth __________________

Date Issued __________________ Place Issued __________________

Present Address: Street Address, City/State/ZIP __________________

Email Address __________________ Cell Phone __________________

NEXT OF KIN:

Name __________________ Relationship __________________
Street Address, City/State/ZIP

__________________________________  ______________________
Home Phone  Office Phone

__________________________________  ______________________
Email Address  Cell Phone

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY (if other than person listed above)

__________________________________  ______________________
Name  Relationship

__________________________________
Street Address, City/State/ZIP

__________________________________  ______________________
Home Phone  Office Phone

__________________________________  ______________________
Email Address  Cell Phone

__________________________________________  ______________________
(Signature)  Date

Printed Name ______________________________________________________
Attachment 3

ASSUMPTION OF RISK AND RELEASE FROM LIABILITY
Related to U.S. State Department Travel Warning

This Assumption of Risk and Release from Liability pertains to travel to ______________ during ______________.
I, ____________________________________________, wish to travel to ______________ and hereby state that:

1. Travel to ___________ is not required as part of any course or degree program in which I am enrolled or as a condition of current or future employment and that, therefore, my decision to travel to ___________ is entirely voluntary.

2. I understand that certain risks are inherent in any foreign travel experience and I fully accept those risks. These risks may include, but are not limited to, such things as war, quarantine, civil unrest, public health risks, criminal activity, terrorism, exposure to communicable diseases, ill effects of unfamiliar food and water, incidents related to ground, air or water transportation, adverse weather conditions, accident, injuries or damage to property, and other physical, mental, and emotional injury.

3. Indiana University has brought to my attention the U.S. Department of State Travel Warning against travel to ________ by United States citizens dated _________. I have read and fully understand this warning. I am proceeding with my travel plans notwithstanding this State Department Warning.

4. I have been advised that no one can guarantee my safety in ______________ and I have been advised to have adequate insurance before my departure, which should include medical evacuation, repatriation of remains and life insurance. I have been advised that if I am included on my family’s insurance policy, that I should make sure that the coverage is valid overseas for the duration of my travel.

5. I fully understand the above risks involved in the proposed travel and I agree to assume the risks of this travel, including the risk of catastrophic injury or death.

6. I agree for myself, my heirs and assigns, to indemnify, hold harmless, release and forever discharge Indiana University, its Trustees, employees, agents, and cooperating institutions and their offices and agents (if any) from any and all claims and expenses, including reasonable attorney's fees, for any injury, loss, or damage to personal property, including catastrophic injury or death, related to travel to or suffered by me.

Resident’s/Fellow’s Signature ____________________________________________

Date ______________________________________________________________________

Name (printed) ______________________________________________________________________

SIGN AND DATE THIS FORM; GIVE TO YOUR DEPARTMENT HEAD PRIOR TO DEPARTURE