SECTION FOUR – INSTITUTIONAL RESPONSIBILITIES

SPUH POLICY NO: 4. 7
SUBJECT: ROTATION-IN FROM EXTERNAL GRADUATE MEDICAL EDUCATION PROGRAMS

I. PURPOSE

To provide a policy concerning rotations by post graduate trainees from external graduate medical education programs.

II. SCOPE

This policy applies to all Programs and Departments whereby residents/fellows will be rotating into SPUH from external GME programs.

III. DEFINITION

External residents/fellows refers to all interns, residents and sub-specialty residents and fellows enrolled in approved (ACGME/AOA/ADA) GME programs outside of SPUH.

IV. RESPONSIBILITIES/REQUIREMENTS

1. All rotations by external residents/fellows must be approved by the Program Director or Department Chairman and the Director of Medical Education.
2. The SPUH Faculty Rotation Director, Department Chairman or Program Director will develop a letter of agreement which must:
   a) Identify the faculty who will assume both educational and supervisory responsibilities for residents/fellows;
   b) Specify their responsibilities for teaching, supervision, and formal evaluation of residents/fellows;
   c) Specify the duration and content of the educational experience; and
   d) State the policies and procedures that will govern resident education during the assignment.
3. Residents/fellows from external programs must be in an accredited program to qualify as rotating residents/fellows at SPUH. Appropriate qualifications (Permit/Licensure status as well as proof of malpractice insurance) must be verified by the respective SPUH Faculty Rotation Director, Department Chairman or Program Director. Each rotating resident/fellow must possess either a NJ permit or license (or statement of acceptance of out-of-state medical training permit from the NJ BME). Documentation will be kept in the department through which the resident is rotating and the Office of Medical Education (OME).
4. Each SPUH Faculty Rotation Director/ program must prepare a monthly rotation schedule reflecting period of rotation for all residents/fellows rotating in. A copy of the schedule must be provided to the OME.
5. The SPUH Faculty Rotation Director/ program must request and receive the required information (Attachment 1) prior to the start of each rotation. A copy of the information must be submitted to the OME.
6. All rotating residents/fellows must sign an Authorization for Release of Information form (Attachment 2). SPUH Faculty Rotation Directors/ Programs will provide a copy to the OME.
7. The Medical Staff Office (MSO) will authorize issuance of ID for rotating residents/fellows up on receipt of the completed required information checklist (Attachment 1) form the OME.

V. SALARY SUPPORT AND MALPRACTICE INSURANCE

Salary support, all fringe benefits and malpractice insurance coverage must be provided by the originating program unless explicitly stated otherwise in an Affiliation Agreement. Verification of malpractice insurance coverage is required prior to the initiation of the rotation at SPUH and must include the following:

A certificate of insurance naming SPUH as a certificate holder or, if the external program is a self-insured program, actuarial certification of self-insurance funding mechanism issued through the external program's risk management office. Coverage limits of $1,000,000 / $3,000,000. Coverage dates that include the time the resident will be at SPUH. A statement that the coverage includes the resident's activities at SPUH must be included.

VI. AFFILIATION AGREEMENT

If SPUH is listed as an affiliated hospital for any graduate medical education program or if any graduate medical education program consistently rotates residents through SPUH, an Affiliation Agreement must be negotiated in advance.

VII. HOUSING, MEALS, AND PARKING

There will not be any subsidization for housing, meals, or parking by SPUH for rotating residents. This must be communicated to the rotating resident by the Department prior to the initiation of the rotation.

VIII. ORIENTATION AND EVALUATIONS

Rotating residents must be oriented by a member of the Department or Division in which they will be rotating. The Department or division must provide OME the completed resident departmental orientation form and rotation specific evaluation form at the end of each rotation. Individual residents should receive instructions as to the policies and procedures of both the SPUH and the Department or Division pertaining to: safety, parking, library availability, cafeteria hours, laundry facilities, on-call rooms and security issues.

IX. MASTER LIST

A summary of rotating residents/fellows will be prepared by the OME and presented to the Office of Risk Management for information purposes only. This list will also be distributed to the appropriate hospital administrators, program directors and chairs.

Approved by SPUH GMEC July 2006.
Reviewed & Approved: 10/2010
Attachments (2)

ATTACHMENT-1

New Rotating-In Resident/Fellow Information (*)

To be provided by the Program Director

To the SPUH Office of Medical Education prior to the start of the Rotation

Name: _____ PGY-Level: _____ Program: _____

Information	Attached	Pending/NA
Institutional		
❑ *Executed Business Associate Agreement with ACGME		
❑ Most recent JCAHO Accreditation letter		
❑ Institutional Affiliation Agreement (if applicable)		
Program		
❑ *Executed Program Director's Rotation Agreement Letter		
❑ *Most recent ACGME/RRC program Accreditation Letter		
❑ *Resident Master rotation Schedule / reflecting SPUH rotation		
Resident		
❑ *****Executed Residency/Fellowship contract		
❑ *Privileges – List of procedures		
❑ *****Medical School Diploma, Transcripts		
❑ Goals & objectives for the rotation		
❑ Rotation Specific Resident Evaluation Form		
❑ *Malpractice Insurance coverage certificate while at SPUH		
❑ NJ Permit/License, Registration and DEA (as applicable)		
❑ *****Current CV		
❑ Certification: BLS/ALS/ATLS/PALS/NALS (as applicable)		
❑ *Employee Health Service clearance (including immunizations)		
❑ *****Employment Authorization (SS Card, Passport, Work Permits/Visa)		
❑ *****ECFMG certificate (if applicable)		
❑ HIPAA In-service		
❑ *Background Check clearance		
❑ *****A signed Authorization to Release Information form (attached)		
❑ ***For PGY-2 and above**: Written evidence of prior Residency training in US, (name of institution, program completed, dates attended) or Letter from previous program director or Residency contract		

Note: Please include this check list with information package for each resident. Information package must include all items with (*) to be cleared for ID. The information is necessary for compliance with regulatory and accreditation requirements to which SPUH is subject. **Thank you.**

_____ _____

Residency Coordinator Date Program Director Date

To Be Completed by the SPUH Office of Medical Education

Cleared for ID: ( ) Yes ( ) NO	
Signature:	

ATTACHMENT-2

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, am currently employed or seeking employment with, or intend to rotate to or otherwise to practice in my profession at, Saint Peter's University Hospital, New Brunswick, New Jersey ("SPUH").

I understand that as a condition of my employment, appointment or rotation, SPUH must verify my licensure, education and training, character, performance and conduct, and physical and mental capacity. I understand that SPUH may contact schools, institutions and programs where I received education or training (including, for example, any high school, college, university, medical school, hospital, clinic or education program), and that SPUH may contact professional organizations and federal or state government agencies and authorities that govern, oversee or monitor my profession, education or licensure (including, for example, any medical specialty board, and State Departments of Health or Education).

I hereby authorize SPUH to request, and I hereby consent to and authorize the disclosure to SPUH of, any and all information pertaining to my licensure, education and training, character, performance and conduct, and physical and mental capacity.

A photocopy of this authorization is hereby deemed as effective and valid as the original, which will remain on file with SPUH.

_____	_____
Print Name	Signature
_____	_____
Social Security Number	Date of Birth
_____	_____
Date	Current Address