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

Created: 1994
Reviewed: 2/01, 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)

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

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

2/15/2019
Date

2/20/19
Date
AWAY ROTATION (DOMESTIC) REQUEST
FOR AFFILIATION AGREEMENT & ROTATION APPROVAL

ATTACHMENT 1

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