

The University of Cincinnati Medical Center/College of Medicine  
Graduate Medical Education

Request for Off-Site Training

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**Purpose of Form:**

This Form must be completed for any rotation by any House Office outside of an Affiliated Hospital NOT APPROVED by the Accrediting Council for Graduate Medical Education (ACGME) for your program.

This Form must be completed for any requested rotation for which the University of Cincinnati Medical Center does NOT receive compensation through Graduate Medical Education Reimbursement mechanisms.

**Completion of Form:**

Request must be written and approved by Program Director and sent to the Office of GME at least four (4) months prior to the anticipated start date of rotation.

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Attach a description of the Rotation including a statement from the resident as to why this rotation is needed and if a comparable experience can be obtained at the University of Cincinnati Medical Center or Affiliated Institutions. The Program Director must submit a written letter of support for the rotation.

Send the form and attachments to the Office of GME. The Office of GME will return a copy to the Department indicating whether or not approval has been granted.

**NOTE: In the event a rotation is begun prior to approval, the Department will be charged for such rotation at the normal recharge rate.**

**NAME OF RESIDENT/FELLOW:** [Insert Name of Resident/Fellow]

**DEPARTMENT:** [Insert Department Name]      **SS#:** [Insert Social Security Number]

**UCMC RESIDENT/FELLOW LEVEL:** [Insert Resident or Fellow]      **PGY LEVEL:** [Insert PGY Level]

**REQUESTED ROTATION SITE:** [Insert Rotation Site]

**ADDRESS:** [Insert Address]

**DATES OF ROTATION: begin date** [Insert Date]    **end date** [Insert Date]

**ROTATION SITE SUPERVISOR:** [Insert Site Supervisor Name] **TELEPHONE #:** [Insert Telephone Number]

**HOW IS THIS ROTATION TO BE REIMBURSED:** [Insert Text]

*DEPARTMENT APPROVAL*

*UNIVERSITY OF CINCINNATI MEDICAL CENTER APPROVAL*

\_\_\_\_\_  
*Program Designee*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Designated Institutional Officer for GME*

\_\_\_\_\_  
*Date*