The following procedure must be followed for University of Chicago Medical Center (UCMC) residents/fellows interested in participating in any off-site activity related to clinical training. No rotation is authorized to begin until this form receives all necessary approvals.

1. It is the responsibility of the training program to make all arrangements for the off-site elective and to follow all UCMC procedures prior to engaging in the off-site elective. Failure to follow relevant procedures may jeopardize malpractice coverage for that rotation.

2. The training program must complete and submit to the GME office (J-141) the attached Off-Site Elective Application Form which includes a concise, specific description of the elective rotation, the name of the visiting institution, the faculty supervisor who will perform the resident/fellow’s evaluation and the party responsible for providing malpractice insurance coverage. The completed form should be submitted 4 weeks prior to the requested start date.

3. A completed Program Letter of Agreement (PLA) is required to be submitted with the completed Off-Site Elective Application Form.

Revised: July 2009
UNIVERSITY OF CHICAGO AND UNIVERSITY OF CHICAGO MEDICAL CENTER
Application for Extension of Professional Indemnification
(Malpractice Coverage) for
Off-Site Residency Rotation

Name _______________________________________________________________                       Date _______________

Department/Section ________________________________________ UCMC Start Date________ UCMC Ending Date _______

Name of Off-Site Location: ___________________________________________________________________________________

** Off-Site Address:___________________________________________________________________________________________

Off-Site Immediate Supervisor Name: ____________________________   Title: _____________________________

Off-Site Supervisor Phone:_________________________________    Fax: ______________________________________

Off-Site Starting Date:   ____________________            Off-Site Ending Date:   __________________________

Description of proposed elective experience: _______________________________________________________________________
________________________________________________________________________________________________________

Will you be (please check all that apply):
   _____ Observing?
   _____ Performing Surgery? Please Specify: __________________________
   _____ Performing Clinical Activity?
   _____ Other? Please Specify: __________________________

If the immediate supervisor will not be completing the resident evaluation, please indicate the name of the person who will do so:
__________________________________________

Is your off site activity pursuant to a written agreement, such as an affiliation agreement or program letter of agreement?

    ________ No, Please contact your Program Director and/or the Graduate Medical Education Office to determine whether a written
              agreement is necessary for your off site activity.
    ________ Yes, (Please attach)

Do you need a letter certifying coverage?     _____ No     _____ Yes, To whom? _______________________________________

**If elective is outside of Illinois, please attach a copy of your medical license in the state in which the elective will be performed.

Please obtain the approvals below before returning the completed form to:
Office of Legal Affairs, 5841 S. Maryland Ave., MC1132, Chicago IL 60637; Phone: 2-1057; Fax: 2-9310, Room G-104.

    ________________________________ _________________________
    Resident/Fellow Date

    ________________________________ _________________________
    Immediate Supervisor of Off-Site Location Date

    ________________________________ _________________________
    UCMC Program Director Date

    ________________________________ _________________________
    Approved by Department Chairman Date

    ________________________________ _________________________
    Approved by Graduate Medical Education Date

For OLA use only.

    ________________________________ _________________________
    Malpractice Extension Approved: Ex. Dir. UCH Prof. Liability Indemn. Plan Date