

Stanford Hospital & Clinics

Notification of Away Rotation

Malpractice Coverage for House Staff Working Outside Approved Practice Sites

Dear Program Director:

Name of Resident:

Has been approved for away elective Yes Y No N
Needs malpractice coverage Yes Y No N

To process this request we need the following information:

1. Is this an elective or will this require a shift in rotation assignments:

2. Date of the activity:

From: To:

3. Are compatible services/experiences available through SUMC or its affiliates?
Yes Y No N

4. Name of the facility where the activity will be carried out:

Address:	
City:	
State:	Zip: <input style="width: 50px;" type="text"/>
Fax:	
Contact:	
Phone:	

Name of Institution/Company:

Address:	
City:	
State:	Zip: <input style="width: 50px;" type="text"/>

5. Is this activity going to be carried out on a repeated basis?

Yes No

6. Frequency per week or month?

Duration of involvement?

7. Goals and Objectives of the elective:

8. Is certificate of insurance coverage needed: Yes Y No N if so, amount of coverage \$ _____ any special instructions?

Program Director:

Signature

Date

Deliver, mail or fax form to Ann Dohn, Office of Graduate Medical Education, HC 435, Stanford Hospital and Clinics, 300 Pasteur Drive, Stanford, CA 94305-5207 Fax: (650) 723-3045; for more information, call Ann at (650) 723-5948.

Office use only:

Director, Office of Graduate Medical Education:

Signature

Date

Chief of Staff:

Signature

Date