CARILION CLINIC | VTC School of Medicine
Graduate Medical Education

Out-Rotation Agreement
Carilion Medical Center
&

Carilion Medical Center (Sponsor) in Roanoke, VA is requesting that a Resident in one of its accredited GME programs be allowed to complete an out rotation involving supervised patient care at (Facility). "Resident" as used below means intern, resident, or fellow. All Carilion Clinic Residents must be approved by the Carilion Clinic Designated Institutional Official (DIO), as well as the appropriate individuals at the Facility prior to commencing an out rotation.

Section 1: *To be completed by the Carilion Clinic Resident Applicant.* **PLEASE COMPLETE ONLINE OR PRINT LEGIBLY**.

Name (First, Middle, Last) ☐ M.D. ☐ D.O. ☐ Male ☐ Female Last 4 of SSN

Address (Street, City, Zip) Mobile Number D.O.B. (MM/DD/YYYY)

Email Address

Emergency Contact Relationship Phone(s)

Virginia Medical License No. Expiration Date (MM/DD/YYYY) NPI No.
**Residents may be required to obtain an appropriate state license for rotations outside of Virginia*

Medical School (full name) Graduate Date (MM/DD/YYYY)

Current Residency Program Current PGY Level

Total Number of All Post Graduate Years of Training Home or Sponsoring Institution

Address (Street, City, Zip) Mailing Address

Carilion Program Director Phone Email

Carilion Program Manager Phone Email

Out Rotation Requested Dates (MM/DD/YYYY to MM/DD/YYYY)

Name of Out Rotation Program Director or Supervising Physician Site Contact (if known) Phone

Infection Control

Y ☐ N ☐ I am immune to rubella, rubeola, and varicella
Y ☐ N ☐ I am free of active pulmonary tuberculosis
Y ☐ N ☐ I have had a PPD skin test within previous year. Date of last PPD (MM/DD/YYYY):
Y ☐ N ☐ Results of PPD were negative. (If you answered no, you must attach proof of a negative chest x-ray obtained within the last year).
Y ☐ N ☐ I am immune to hepatitis B

Please read the following and attest to the fact that you agree with them by signing your name below.

- I am responsible for complying with all applicable laws, statutes and regulations and the policies, procedures, and rules of the Facility and safeguarding confidential information, including but not limited to patient information disclosed orally, in writing, or by any other media or manner, obtained during my participation in my Out-Rotation.
- I am responsible for making appropriate arrangements for transportation to and from the Facility and, if necessary, appropriate housing arrangements.
- I am responsible for providing my own health insurance. In the event of an emergency, the Facility shall provide emergency care as is provided to its employees, but I shall be responsible for any charge thus generated.
- I am responsible for providing the Facility with any evaluation form(s) and the address for submission of any evaluation form(s) that my Sponsoring Institution wants the Facility to complete regarding my Out-Rotation.
- I understand that Carilion Medical Center has the sole right to exclude or terminate me from participation in an Out-Rotation in the event that I am not performing to the satisfaction of the Facility, including, but not limited to material breaches of any of the Facility's rules and policies, or am interfering with the operations of the Facility.
- I understand that the Facility has the sole right to determine and designate, and from time to time to change, those patients, patient groups, and clinical areas which may be included in my Out-Rotation.
- I am not debarred, excluded or otherwise precluded from participating in any federally funded health care program, including but not limited to Medicare and Medicaid.
- Finally, I understand that I am not an employee of the Facility and the Facility has no responsibility for providing compensation or benefits to me during my Out-Rotation. During my Out-Rotation, I will not hold myself out as the employee or agent of the Facility.
- I have attached Goals and Objectives for the above-requested Out-Rotation.

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Signature | Printed Name | Date (MM/DD/YYYY)

Section 2: *To be completed by the Sponsoring Institution.* **PLEASE COMPLETE ONLINE OR PRINT LEGIBLY**.

The Sponsor agrees to the following.

Term: The term of this agreement between the parties shall be for the duration of the requested Out-Rotation. The Facility does, however, maintain sole authority for determining the Resident's ability to participate in the Out-Rotation.

Professional Liability: At its own expense, Carilion Clinic will provide professional liability coverage for each Resident in amounts of not less than the following limits: (i) the per claim limit shall be equal to or greater than the damage cap for medical malpractice claims against physicians in the Commonwealth of Virginia, as increased from time to time by Va. Code § 8.01- 581.15; (ii) the annual aggregate limit shall be equal to or greater than three (3) times the damage cap for medical malpractice claims against physicians in the Commonwealth of Virginia, as increased from time to time by Va. Code § 8.01-581.15. If Carilion Clinic maintains a claims-made policy, Carilion Clinic shall also provide, at its own expense, "tail" insurance coverage upon termination of its policy extending to all periods during which the Resident was in an Out-Rotation at the Facility under this agreement. The obligations of Carilion Clinic to maintain tail coverage under this paragraph shall survive termination or expiration of this agreement. Carilion Clinic shall provide the Facility with certificates from the insurance company or companies evidencing this coverage. Nothing herein shall prohibit Carilion Clinic from self-insuring such liability coverage.

Billing: To the extent permitted by applicable law and regulations, the Facility may include on its Medicare and Medicaid cost reports the time that the Resident is in a Out-Rotation at the Facility. The Facility and its attending physicians shall have sole responsibility for billing third-party payers, including Medicare and Medicaid, for all patient care services provided by the Facility and its attending physicians, including, to the extent permitted by applicable laws and regulations, the care rendered by attending physicians in which the Resident participates or for the services of attending physicians of the Facility.

Financial Support and Benefits: Carilion Clinic shall be solely responsible for providing salary, health, and welfare benefits to the Resident during the Out-Rotation, and the Resident shall not be considered an employee of the Facility. The parties shall at all times, be independent contractors and not employees or agents of another and shall not hold themselves out as employees or agents of each other.

I approve the Out-Rotation described above and verify that this Resident is in good standing in the program.

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Printed Name of Program Director, Carilion Clinic | Signature | Date (MM/DD/YYYY)

_____

Printed Name of DIO, Carilion Clinic | Signature | Date (MM/DD/YYYY)

Section 3: *To be completed by the Facility.* **PLEASE COMPLETE ONLINE OR PRINT LEGIBLY**.

I approve the above Resident Out-Rotation to the Facility including the attached Goals and Objectives and will ensure that adequate resident supervision will occur.

Printed Name of Physician | Signature | Date (MM/DD/YYYY)

☐ Program Director ☐ Supervising Physician

Email Address | Phone

Physical Address of Program Director or Supervising Physician

Printed Name of Facility | Printed Address (if different from above)

Section 4: *To be completed by the Facility.* **PLEASE COMPLETE ONLINE OR PRINT LEGIBLY**.

I approve the above Resident Out-Rotation to the Facility and agree to the terms of this Agreement as written above.

Printed Name | Title | Signature | Date (MM/DD/YYYY)

Physical Address (Street, City, Zip)

Notes:

Send completed agreement with all required documentation attached to the Program Director or Supervising Physician of the Facility. Please send a copy to Carilion Clinic Graduate Medical Education, 1 Riverside Circle, Roanoke, VA 24016

Phone: 540-266-5843 Fax: 540-983-1190