

Section 4 Assignment of Rotating Residents or Fellows	Date Revised: January 2001, August 2001, September 2004, June 2006, July 2017, February 2020
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**Application Procedure for
Residents Rotating From Other Institutions
For Electives at Saint Louis University School of Medicine**

Application procedures are as follows:

1. A separate application **must** be completed for each elective rotation to which the resident is applying.
2. Each application **must** be complete including resident data, verifications and appropriate signatures before approval is given. Applications should be received at least **60 days** prior to the anticipated rotation start date or training may be delayed. Out-of-state rotators may require longer processing times due to the need to obtain a Missouri physician's license. Additionally, during the high processing times for licensing in January and June, issuance of a Missouri physician's license could be significantly delayed.
3. The applicant completes Section I of the application and is responsible for having Sections II and III completed by the appropriate official of the institution in whose residency program the applicant is currently a member.
4. **The applicant is to sign the Memorandum of Agreement (M.O.A.).**
5. The applicant should return the application form of the Memorandum of Agreement along with copies of Missouri License, Missouri BNDD certificate, ECFMG Certificate, Federal DEA, Proof of Malpractice Insurance, and CV. The applicant must also show verification of the following: drug testing, criminal background check, HIPPA training, and health status. For rotations at Saint Louis University Hospital he/she must also complete SLUH orientation and IS security training.
6. Upon receipt of the application and Memorandum of Agreement the Saint Louis University Program Director will complete Section IV of the application; obtain review and approval by the Department Chairperson of the M.O.A. and forward both the application and M.O.A., along with all necessary documents to the Saint Louis University School of Medicine Office of Graduate Medical Education, Schwitalla Hall, M260, for M.O.A. final review, approval, and execution.

A copy of all materials will be retained in the GME Office, and shared as necessary with affiliated institution officials. Originals of the completed application and the M.O.A. will then be forwarded to both the Saint Louis University Program Director and the rotating resident's sponsoring institutions Program Director.

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**Application
For Residents Rotating From Other Institutions
For Electives at Saint Louis University School of Medicine**

Directions: Please complete Section I; have Sections II and III completed by your sponsoring institution; and attach copies of your Missouri License, Missouri BNDD certificate and Federal DEA certificate.

Return application to: Saint Louis University Program _____
 Saint Louis University Residency Program Director:
 Name: _____
 Address: _____

 Phone: _____

Section I To be completed by the applicant:

Last Name: _____ First Name: _____ MI: _____ Degree: _____
 Date of Birth: _____ MO License #: _____ BNDD #: _____ DEA #: _____
 SS#: _____ Email Address: _____ Phone: _____

Current Residency Institutional Sponsor: _____
 Current Residency Program: _____ Start Date: _____
 Phone #: _____ Fax #: _____ Pager #: _____
 Saint Louis University Rotation: _____ Location: _____
 Rotation Start Date: _____ Rotation End Date: _____

Prior US training-Complete the following:

Prior Residency Program #1: _____
 Location (city and state): _____ Start Date: _____ End Date: _____
 Prior Residency Program #2: _____
 Location (city and state): _____ Start Date: _____ End Date: _____

Medical School: _____ Graduation Date: _____
 ECFMG Certification Number: _____ ECFMG Certification Date: _____
 (a copy of the ECFMG Certificate must be attached)
 Resident's Signature: _____ Date: _____

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Section II To be completed by the applicant's current Residency Program Director:

1. The resident named above is in good standing and currently a member of the _____ residency program.
2. On the dates requested for rotation, the resident is a PGY _____ level resident.
3. An evaluation ____ will ____ will not be requested at the end of the elective rotation.
4. The resident has our approval to take this elective.

Residency Program Director (Print)

Residency Program Director (Signature)

Name of Sponsoring Institution

Date

Section III To be completed by an official of the institution in whose program the resident is currently a member:

1. Personal health coverage is in effect while the resident is away from our program
2. Malpractice insurance is extended to cover resident while the resident is on this elective rotation. (ATTACH PROOF OF MALPRACTICE INSURANCE.)
3. The resident has our approval to take this elective.

Dean/President/CEO of Sponsoring Institution
(Print)

Name of Sponsor

Dean/President/CEO of Sponsoring Institution
(Signature)

Mailing Address

Title

City, State, Zip Code

Date

Telephone Number

Section IV: To be completed by Saint Louis University School of Medicine Residency Program Director:

The resident ____ does have my approval to take the elective rotation indicated below:

SLU Program: _____

Elective: _____

Dates of Rotation: _____

Program Director: _____
Name (printed)

Program Director: _____
Signature Date

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SAINT LOUIS UNIVERSITY AND AFFILIATED CLINICAL SITES

CONFIDENTIALITY STATEMENT

The undersigned hereby acknowledges his/her responsibility under applicable federal law and the rotational agreement between _____ ("Sponsoring Institution" and trainee) and Saint Louis University to keep confidential any information regarding Saint Louis University affiliated clinical sites ("Sites") patients and proprietary information of these entities. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Sites, except as required by law or as authorized by Sites. The undersigned agrees to comply with any patient information privacy policies and procedures of the University and Hospital. The undersigned further acknowledges that he or she has viewed a recording of the Sites patient information privacy practices in its entirety and has had an opportunity to ask questions regarding the Site's and University's privacy policies and procedures and privacy practices.

INFORMATION SECURITY STATEMENT

I understand that in the performance of my duties in affiliation with Saint Louis University and affiliate clinical sites ("Sites"), I am required to have access to and/or am involved in approved research necessitating access to patient care data. I acknowledge the patient's right to confidentiality and will only access patient data to the extent necessary to perform my job responsibilities. I hereby agree to maintain the confidentiality of the patient care data at all times, both on premises and off. I further understand that any information relating to Saint Louis University and Sites is to remain confidential and may not be disclosed without appropriate administrative approval. I understand that a violation of patient confidentiality standards may result in disciplinary or a legal action against me.

Signature

date

Printed Name

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HEALTH AND BACKGROUND SCREENING ATTESTATION

HEALTH OF PROGRAM PARTICIPANTS.

Sponsoring Institution (or participant) , _____, attests the Program Participant listed below has completed the following health screenings or documented health status as follows, and the trainee and institution will inform Saint Louis University with any changes with respect to the attestations.

1. Tuberculin skin test within the past 12 months or documentation as a previous positive reactor or a chest x-ray taken within the past 12 months; and
2. Proof of Rubella and Rubeola immunity by positive antibody titers or 2 doses of MMR; and
3. Varicella immunity, by positive history of chickenpox or proof of Varicella immunization; and
4. Proof of Hepatitis B immunization or completion of a certification of declination of vaccine, if patient contact is anticipated.
5. Negative drug screen.

BACKGROUND CHECKS. Sponsoring Institution has conducted a retrospective background check on all residents assigned to the program prior to their participation in clinical activities. Unless Saint Louis University Hospital is notified in writing, all background checks are negative. The background check included the following:

1. Social Security number verification.
2. Criminal Search (7 years)
3. Violent Sexual Offender & Predator registry
4. HHS/OIG/GSA

PARTICIPATING RESIDENT (SIGNATURE)

Sponsoring Institution acknowledges this information will be available to Saint Louis University Hospital as reasonably necessary.

SPONSORING INSTITUTION OFFICIAL:

Name: _____

Signature: _____

Title: _____