USF Health
Morsani College of Medicine

GRADUATE MEDICAL EDUCATION
OFF-SITE ROTATION APPLICATION FORM

MUST BE RETURNED TO GME OFFICE SIXTY (60) DAYS PRIOR TO THE START OF OFF-SITE ROTATION (120 DAYS PRIOR IF ANY AGREEMENTS OR CONTRACTS ARE REQUIRED)

Resident Name: _____ **PGY Level:** _____

Are you currently on a J-1 Visa? ☐ Yes ☐ No

If on a J-1 visa, please complete the ***ECFMG Required Notification of Off-Site Rotation/Elective***

Current USF Residency Program: _____

Off-Site Rotation **START DATE:** _____ **END DATE:** _____

PHYSICAL Location of Off-Site rotation:

Name _____

Address _____

City, State, Zip _____

Phone _____

Supervisor while at Rotation Site: _____

Nature of Rotation / Assignment: ☐ Patient Care ☐ Didactics/Education ☐ Research ☐ Observership

For rotations involving patient care, provide evidence of appropriate out-of-state or international licensure. If additional licensure is not required or not applicable, the program must attach written confirmation from the rotation supervisor verifying that no additional licensure is required.

☐ Attached ☐ In Process ☐ Not Applicable

***FINAL APPROVAL WILL NOT BE GRANTED UNTIL AFTER PROOF OF LICENSE IS PROVIDED

RESIDENT/FELLOW SIGNATURE: _____ **Date:** _____

PROGRAM: Please indicate how Off-Site Rotation is being funded:

☐ **Resident/Fellow taking Annual Leave** (*Annual Leave only allowed for rotations less than 2 weeks and considered on a case-by-case basis. Trainee must also sign the waiver/release)*

☐ **Paid by Off-Site Location** (*If checked, complete the New Rotation / Assignment Request Form)*

☐ **USF MCOM Program Funded**

SIGNATURE OF PROGRAM DIRECTOR: _____ **Date:** _____

Revised 3/18/2026

USF Health
Morsani College of Medicine

NOTE: Dates for off-site rotations must be entered into New Innovations as "off-site" rotation; not as an elective.

Return Completed, Signed Letter of Approval (with Attachments) to: Caroline Kuehling, Graduate Medical Education, via e-mail at ckuehling@usf.edu

==========

APPROVALS (GME Office Will Obtain):

DEPARTMENT/AFFILIATE APPROVAL:

SIGNATURE OF DEPT REPRESENTATIVE/AFFILIATE _____ Date: _____

DEPT REPRESENTATIVE/AFFILIATE NAME _____Title: _____

PROGRAM LETTER OF AGREEMENT OR AFFILIATION AGREEMENT:

☐ Current Program Letter of Agreement or Affiliation Agreement for location

☐ Not required for off-site rotation

OFF-SITE ROTATION REQUEST REVIEWED BY GMEC:

☐ YES ☐ NO ☐ NOT APPLICABLE

MALPRACTICE INSURANCE:

☐ Covered by USF SIP and effective for this off-site rotation.

☐ International activity covered by USF SIP only up to $200,000 per claim / $300,000 per occurrence. Physician bears responsibility over these amounts.

☐ Volunteer activity covered by USF SIP only up to $200,000 per claim / $300,000 per occurrence. Physician bears responsibility over these amounts.

EXEC. DIR., SELF INSURANCE PROGRAM: _____ Date: _____

DIRECTOR, GME: _____ DATE: _____

SR. ASSOCIATE DEAN, GME: _____ Date: _____