

# REQUEST FROM OUT-OF-STATE RESIDENT TO PERFORM ELECTIVE ROTATION

## UNIVERSITY OF HAWAII \_\_\_\_\_ RESIDENCY PROGRAM

Hawaii Residency Programs, Inc. • University of Hawaii, John A. Burns School of Medicine • Honolulu, Hawaii

**APPLICATION FEE: \$ 50.00 (NON-REFUNDABLE UNLESS CXL BY HRP)**

### **PART I: To be completed by resident applying for elective.**

NAME: \_\_\_\_\_ PGY LEVEL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE (home/cell/pager): \_\_\_\_\_ EMAIL: \_\_\_\_\_

CURRENT PROGRAM: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PROGRAM CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ELECTIVE DESIRED: \_\_\_\_\_

ELECTIVE DATES: FROM \_\_\_\_\_ TO \_\_\_\_\_ TOTAL WEEKS: \_\_\_\_\_

**(4 WEEK MINIMUM ELECTIVE ROTATION, UNLESS OTHERWISE APPROVED)**

I understand out-of-state residents doing an elective with the Hawaii Residency Programs do not receive any type of compensation while assigned to an elective rotation and I further understand that I am solely responsible for securing housing accommodations, making my own travel arrangements, as well as any other transportation arrangements necessary while doing this elective. I understand I am responsible for providing the following: **1)** proof of my malpractice coverage, **2)** proof of my personal health coverage, **3)** written documentation from my Program Director that I am a resident in good standing, and **4)** securing a temporary resident medical license with the State of Hawaii Medical Board (*Program Director must address a separate letter directly to the Hawaii Medical Board verifying that I am a resident in good standing*). **This required documentation must be submitted prior to the commencement of training. No resident will be allowed to commence training prior to submission of this documentation and approval of this request.**

RESIDENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### **PART II: To be completed by resident's current training program's Program Director or authorized designee.**

I verify that the above-named resident is a resident in good standing with our residency program; that while on this elective the above-named resident has malpractice coverage, and that this resident has personal health coverage (*Must provide written documentation on program letterhead. Coverage must include private and work-related injuries.*).

At the conclusion of this elective, our program  **requires**  **does not require** an evaluation of the resident's performance. (*Please provide evaluation form or we will use our own form.*)

NAME OF PROGRAM DIRECTOR (OR DESIGNEE): \_\_\_\_\_

OFFICIAL TITLE: \_\_\_\_\_ PHONE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### **PART III: To be completed by preceptor or authorized designee of elective rotation.**

THE RESIDENT IS TO REPORT TO: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_:\_\_\_\_ AM / PM

SPECIAL INSTRUCTIONS: \_\_\_\_\_

NAME OF PRECEPTOR: \_\_\_\_\_ TITLE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### **PART IV: To be completed by Program Director or authorized designee of UH Residency Program.**

Admission of the above-named resident to the elective stated in Part I for the specified period is:  **APPROVED**  **DENIED**

PRINTED NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Please return completed application to:

<b>PROGRAM:</b>		
<b>ATTN:</b>		
<b>ADDRESS:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP:</b>
<b>PHONE:</b>	<b>FAX:</b>	
<b>EMAIL:</b>		

***SUBMISSION DEADLINE: 3 months prior to elective rotation***

6/2005