



Continuum Health Partners, Inc.

BETH ISRAEL MEDICAL CENTER IN-ROTATION/ELECTIVE AUTHORIZATION FORM

11. Inclusive Dates of Rotation/Elective: From: _____ To: _____
(Month/Day/Year) (Month/Day/Year)

12. Length of Rotation/Elective: _____ day(s), week(s) month(s) 13. Number of House officers: _____
(Total #) (Circle One)

14. Total FTE (s): _____ 15. PGY Level: _____
(# of days x # of residents divided by 365) (Current training level)

MANDATORY)

16. Specify policies and procedures that will govern residents while on rotation: _____ BIMC By-Laws
_____ Sponsoring Institution

(PLEASE HAVE ALL PARTIES SIGN & DATE FORM BEFORE SUBMISSION TO BIMC GME OFFICE)

Home (Sponsoring) Program Director (Type/Print Name) Home (Sponsoring) Program Director's (Signature) Date

Home (Sponsoring) Department Chair (Type/Print Name) Home (Sponsoring) Department Chair (Signature) Date

Host (BIMC) Program Director (Type/Print Name) Host (BIMC) Program Director's (Signature) Date

Host (BIMC) Department Chair (Type/Print Name) Host (BIMC) Department Chair (Signature) Date

For BIMC GME Office Use Only
Approved: _____ Date: _____
Director, Graduate Medical Education