# Visiting Resident / Fellow Rotation Policy

Medicare permits hospitals to claim for reimbursement any resident or fellow who rotated to their facility within a cost report year. Therefore, residents and fellows from outside institutions (hospitals not affiliated with the University at Buffalo [UB]) who rotate with any University at Buffalo (UB) sponsored training program must have their time reported on the same basis as University at Buffalo (UB) residents.

Prior to accepting trainees in your department, obtain written verification that:

1. They are covered by their employers’ malpractice insurance for rotations at UB-affiliated hospitals.
2. Their sponsoring institution will continue to provide salary and benefits during the rotation.
3. The facility that employs them understands that they will be claimed for Medicare reimbursement by UB affiliated hospitals.

Required documentation:

* Letter from the UB program director accepting the resident or fellow and agreeing to goals and objectives, evaluation requirements, and any other requirements of the rotation
* Completed UB Visiting Resident Application and Agreement (attached)
* Copy of Social Security Card
* Copy of ACLS Certification Card
* Copy of Medical School Diploma with certified translation if not in English
* Current CV updated to start of rotations with UB program including detailed information on all ACGME-accredited training
* Health Data Summary (attached)
* Copy of ECFMG certificate, if applicable
* Copy of all visa approval notices and I-94s, if applicable
* Letter from resident’s/fellow’s program director granting permission for the rotation and outlining the goals and objectives of the rotation, and evaluation requirements
* Copy of the face sheet from the current malpractice provider listing the appropriate UB affiliated hospital(s) as covered entities with no less than $1.3M/$3.9M coverage on occurrence basis or with tail coverage for the period of rotations with the UB program
* Letter from the institution employing/sponsoring the visiting resident/fellow stating that, for the duration of the rotation:
  + They are solely responsible for continuation of all compensation (salary, benefits, living and meal allowance, etc.);
  + They will not claim the resident on their cost report(s) for this time; and
  + They agree that UB-affiliated hospitals will claim the resident on their cost report(s) for this time

All required information must be submitted to the Office of Graduate Medical Education for review at least 2 MONTHS prior to the proposed start date of the rotation with the UB program. A sample letter listing all required information as well as optional departmental requirements is attached. Applicants for visiting rotations who do not provide all information as stated above will not be approved.

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

Thank you for your inquiry regarding participation in a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ rotation with the University at Buffalo (UB)-sponsored \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ residency/fellowship training program. Your request has been reviewed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Program Director of the UB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ program and has been approved pending receipt of the necessary documentation.

Residents who wish to participate in a rotation with UB sponsored resident/fellow training programs must provide the following information at least four weeks prior to the anticipated start date of the rotation:

* Completed UB Visiting Resident/Fellow Application and Agreement (attached)
* Copy of your Social Security Card
* Copy of your ACLS card
* Copy of your Medical School Diploma with certified translation if not in English
* Your current CV updated to start of rotations with UB program including detailed information on all ACGME-accredited residencies
* Completed Health Data Summary (attached)
* Copy of your ECFMG certificate, if applicable
* Copy of proof of employment eligibility, including visa approval notices and I-94s, if applicable
* Letter from your current program director granting permission for the rotation and outlining the goals and objectives of the rotation and evaluation requirements
* Copy of the face sheet from your current malpractice provider listing the appropriate UB affiliated hospital(s) as covered entities with no less than $1.3M/$3.9M coverage on occurrence basis or with tail coverage for the period of rotations with the UB program
* Letter from the institution employing/sponsoring the visiting resident/fellow stating that, during the rotation:
  + They are solely responsible for continuation of all compensation (salary, benefits, living and meal allowance, etc.);
  + They will not claim the resident on their cost report(s); and
  + They agree that UB affiliated hospitals will claim the resident on their cost report(s)

All required documentation should be sent to me at the following address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sincerely,

Training Program Administrator

UB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Training Program

## VISITING RESIDENT/FELLOW DOCUMENTATION CHECKLIST

Visiting Resident/Fellow Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Institution and Program: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residents who are visiting University at Buffalo (UB) sponsored programs must provide the documentation listed below to the UB GME office 2 MONTHS prior to the proposed rotation start date. When this package is complete, the UB TPA will forward this information to UB GME. Please direct your questions to the UB Training Program Administrator.

**Documentation should be attached to this checklist in the order listed below:**

* Visiting Resident/Fellow Application and Agreement, signed by your Program Director (in section 2)
* Copy of current CV updated to the start of the UB rotation
* Copy of Social Security Card
* Copy of Medical School Diploma (include English translation if not in English)
* Copy of ECFMG Certificate, if applicable
* Completed Health Data Summary (including immunizations, current PPD, etc.)
* Proof of ACLS Certification
* Letter from Program Director indicating his/her permission for the resident/fellow to rotate with a UB program, that the rotation is part of their accredited curriculum and that the resident/fellow is in good standing.
* Copy of the facesheet of the current malpractice carrier with a letter indicating that home program will be responsible for malpractice coverage during the rotation, including all UB affiliated training sites for this rotation
* Letter from the current employer indicating that, during the rotation:
  + All salary and benefits (health insurance, workers’ comp insurance, etc.) will continue
  + Neither they nor any affiliated institution will claim the individual for reimbursement
  + They understand and agree that UB affiliated hospitals will claim the individual for reimbursement
* Employment Eligibility:
  + Copy of US Passport (for US citizens) OR copy of permanent residence documentation
  + If in H-1B status, copy of visa, passport, most recent I-94 card, and evidence of appropriate LCA posting for the UB rotation period
  + If in J-1 or J-2 status, copy of stamped DS-2019, visa, passport, and most recent I-94
  + If in other non-U.S. citizen status, copy of documentation authorizing individual to work in the United States
* Confirmation (letter or email) from Program Director from host UB program confirming that the visiting resident/fellow will not interfere with rotations for residents/fellows in his/her program.
* Competency-based Goals and Objectives for the rotation being requested/proposed.

# VISITING RESIDENT/FELLOW APPLICATION AND AGREEMENT

Please complete Sections 1&2, include a current CV, the UB Health Data Summary, including immunizations and PPD reading, a valid ACLS card (YOU MUST BE ACLS CERTIFIED TO PARTICIPATE). Send at least 2 months prior to the start of the rotation for proper approval to:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Training Program Administrator, University at Buffalo*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Residency/Fellowship Program) (Address)*

# SECTION 1: TO BE COMPLETED BY THE VISITING RESIDENT/FELLOW

# NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_

CITIZENSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICAL SCHOOL/COUNTRY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXACT DATE OF GRADUATION **(DAY/MONTH/YEAR**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DEGREE\_\_\_\_\_\_ ECFMG #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(MUST INCLUDE PHOTOCOPIES OF MEDICAL SCHOOL DIPLOMA and ECFMG CERTIFICATE)***

MEDICAL LICENSE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ISSUING STATE\_\_\_\_\_\_

CURRENT PROGRAM NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CURRENT PGY LEVEL\_\_\_\_\_\_\_

CURRENT INSTITUTION NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSTITUTION PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSTITUTION ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

***(MUST INCLUDE LETTER OF GOOD STANDING FROM CURRENT PROGRAM THAT INCLUDES HIRE DATE)***

PREVIOUS TRAINING (INCLUDE ALL **ACCREDITED** TRAINING PROGRAMS AND DATES)

1.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(MUST INCLUDE PHOTOCOPIES OF CERTIFICATES FROM ANY PRIOR ACGME-TRAINING)***

HOME ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip Cell Phone

EMAIL ADDRESS(ES): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ROTATION NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROTATION DATES FROM:\_\_\_\_\_\_\_\_\_\_\_ TO:\_\_\_\_\_\_\_\_\_\_\_

ROTATION SUPERVISOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UB PROGRAM DIRECTOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The resident will be responsible for ensuring that patient care services are rendered in compliance with all pertinent provisions of federal and state law. The supervisor will be responsible for the resident’s teaching, supervision and evaluation.

SECTION 2: TO BE COMPLETED BY THE VISITING RESIDENT’S/FELLOW’S PROGRAM DIRECTOR

I approve the rotation and the terms of this application as stated above. I have verified all accredited training listed above and the resident’s/fellow’s credentials, and that s/he is in good standing. This appointment is subject to the by-laws of the host UB-affiliated Hospital and of its Medical Board and Medical Staff, as well as any rules and regulations promulgated under those by-laws. We have provided proof of malpractice coverage under our liability insurance plan.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Director Print Name and Title Date

**SECTION 3: TO BE COMPLETED BY THE UNIVERSITY AT BUFFALO PROGRAM DIRECTOR**

I approve the above rotation during specified dates. The resident/fellow will work under direct supervision of faculty in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ residency/fellowship program. The visiting resident will not detract from training of University of Buffalo residents or fellows.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UB Program Director Print Name Date

**SECTION 4: TO BE COMPLETED BY THE UNIVERSITY AT BUFFALO GRADUATE MEDICAL EDUCATION OFFICE**

I approve the above rotation during the specified dates. The rotating resident will not be paid by UB. The appropriate UB-affiliated hospital will claim the rotating resident for Medicare reimbursement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIO, UB GME Print Name Date

VISITING RESIDENT / FELLOW

HEALTH DATA SUMMARY

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME RESIDENCY PROGRAM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PGY-LEVEL \_\_\_\_\_\_\_\_\_\_\_\_\_\_

VISITING UB FOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date of physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. This individual is free from any health impairment which is of potential risk to patients

or which might interfere with the performance of his/her duties, including the habituation

or addiction to alcohol, drugs, or other “substances” that may alter the individual’s behavior.

\_\_\_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_\_\_NO

1. Rubella Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Measles Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Varicella Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date of PPD test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest x-ray (if + PPD) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Hepatitis B status

\_\_\_\_\_\_\_\_\_\_\_\_\_\_HBsAB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HBcAB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HBsAG

Dates of hepatitis B vaccine:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature Date

Cary Hall Rm. 117, 3435 Main St. Bldg. 23, Buffalo, NY 14214-3013

Tel: (716) 829-2012 Fax: (716) 829-3999