PROGRAMMATIC PROFESSIONAL ACTIVITY – SPECIAL CIRCUMSTANCES

Name: Click or tap here to enter text.

Department and Subspecialty Program Click or here to enter text.

Post Graduate Year (PGY) Level: Click or tap here to enter text.

Location of Programmatic Activity: Click or tap here to enter text.

Date(s) of Activity: Click or tap here to enter text.

Description of professional activity: Click or tap here to enter text.

I understand that I may not engage in any programmatic activity outside of this approval process. I further understand that this programmatic activity, if approved, must be counted towards and compliant with the clinical experience and education hours’ institutional and program policies. This programmatic activity must have associated and documented goals, objectives, and evaluations. I also understand that programmatic compensation is processed by the University Of Florida College Of Medicine. The Self Insurance Program (SIP) and Workers Compensation provide coverage for approved programmatic activity.

Participation in programmatic activity requires that the participating resident/fellow to be in good academic standing. Programmatic activity must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program. Permission for participation in programmatic activity may be revoked at any time by the Program Director. Participation in programmatic activity for supplemental compensation without formal approval of the University of Florida Health Science Center, Gainesville, FL administration as outlined, may result in disciplinary action, which may include dismissal from the program.

(Please attach goals and objectives)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPROVAL BY PROGRAM DIRECTOR AND/OR CHAIR OR ASSOCIATE CHAIR

I have reviewed this request and certify that this activity, when combined with the numbers of hours or work per week required of this individual by our program, will not exceed the guidelines established by the Residency Review Committee of our program.

Approved: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disapproved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If approved by the department, approval by the Associate Dean for Graduate Medical Education, Designated Institutional Official (DIO) must be obtained.

Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disapproved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_