Yale-New Haven Medical Center

Write the Name of the Program

Program Letter of Agreement
Non-Standard (one-time elective)

This letter of agreement between _____, of the Department of _____ sponsored by Yale-New Haven Medical Center, (the Sponsoring Institution), and the _____, located at _____**,** (the Participating Institution), is effective the _____ day of _____**,** 20___.

The _____ Program of Yale-New Haven Medical Center seeks to improve the quality of the training program, enhance the residents experience as wells to promote learning in _____ by entering into an affiliation agreement.

CONDITIONS

1. During the time period at the Participating Institution, the _____ **w**ill assume administrative, educational and supervisory responsibility for the residents.

2. While at this institution the residents are expected to learn the following _____ **_____.**

3. The trainee, _____**,** will spend _____ months at the Participating Institution. During this time the residents will continue to be paid by the Sponsoring Institution and will retain all of their benefits from the Sponsoring Institution. The Participating Institution will provide residents with professional liability insurance for the length of the rotation at Participating Institution *(unless prior arrangements are made with the Sponsoring Institution in which case they should be described in this section).*

4. For the length of this rotation, the Participating Institution is responsible for teaching, supervision, and formal evaluation of residents under the responsible attending faculty. At the end of the rotation each resident will be evaluated in writing by the supervising faculty. The evaluation will be discussed with the trainee before the end of the rotation and be included in the trainees permanent file.

5. While at the participating Institution the trainees will be governed by the respective medical policies and procedures of the Participating Institution, which will be provided to the trainees at the beginning of the rotation by the participating institution. For due process the trainees will be governed by Yale-New Haven Medical Center's grievance procedure.

Witness whereof,

_____	_____
Signature & Date	***Signature & Date***
Program Director's Name	***Name of Responsible Individual***
Program Name	***Title of Responsible Individual***
Yale-New Haven Medical Center	***Name of Participating Hospital or Practice***
_____	_____
Signature & Date	***Signature & Date***
Designated Institutional Official	***Name of Responsible Individual***
Yale-New Haven Medical Center	***Title of Responsible Individual***
	Name of Participating Hospital or Practice