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**Resident Transfer Request**

Programs accepting a transfer resident must submit paperwork for approval of the transfer by the chair of the Residency Review Committee. Please include this form with your request:

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| **Receiving Institution Information** |
| Name of Institution |  |
| Name of Resident |  |
| Transfer into which training year? |  |
| Effective Date of Transfer |  |
| Completion Date of Training  |  |
| The program director attests that resident is transferring into an open position | **Yes** | **No** |
| For an off-cycle transfer, the program director attests that the transfer will not result in exceeding the number of approved positions in each year of training. | **Yes** | **No** |
| The program director has reviewed and verified all information regarding previous educational experiences and the resident’s progress toward and successful achievement of competencies and assigned activities which have been validated by an assessment. | **Yes** | **No** |

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| **Releasing Institution information** |
| Name of Institution |  |
| Dates of Training | Start: [mm/dd/yy] | End: [mm/dd/yy] |
| Did the resident train at any other institutions? If yes, please list all previous institutions and dates of training. |  |
| The program provided all required documentation, including completed rotation assessment forms. | **Yes** | **No** |
| Resident passed parts I and II of the APMLE exam | **Yes** | **No** |

A $250 fee must be received from the institution within 30 days of the resident’s acceptance. If payment is not made within 30 days, or if CPME is notified after more than 31 days of acceptance, the fee for the resident transfer will be $1,000.

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| ***Complete the following chart to provide information about the rotations completed and scheduled.*** |
| **Rotation** | **Completed at/Assessed by the Releasing Institution**  | **Scheduled during remainder of training\*** |
| **Required Rotations:** |
| Anesthesiology |  |  |
| Behavioral Sciences |  |  |
| Emergency Medicine |  |  |
| Family Practice |  |  |
| Infectious Disease |  |  |
| Internal Medicine |  |  |
| Medical Imaging |  |  |
| Pathology |  |  |
| General Surgery *(competencies & assessments separate from vascular surgery)* |  |  |
| Podiatric Medicine |  |  |
| Podiatric Surgery |  |  |
| **Medical subspecialty rotations (include training in at least *two* of the following)** |
| Burn Unit |  |  |
| Dermatology |  |  |
| Endocrinology |  |  |
| Geriatrics |  |  |
| Intensive/Critical Care |  |  |
| Neurology |  |  |
| Pain Management |  |  |
| Pediatrics |  |  |
| Physical Medicine and Rehabilitation |  |  |
| Rheumatology |  |  |
| Wound Care |  |  |
| Time spent in the ***Infectious Disease*** + time spent in the ***Internal Medicine*** and/or ***Family Practice*** rotation + time spent in the ***two Medical Subspecialty*** rotation = at least ***three full-time months*** of training: | Yes | No |
| *If no, please provide an explanation:*  |
| **Surgical subspecialty rotation includes training in at least *one* of the following:** |
| Orthopedic Surgery |  |  |
| Plastic Surgery |  |  |
| Vascular Surgery |  |  |
| **Other rotations:** |
|  |  |  |
|  |  |  |
|  |  |  |
| Time spent in residency training will total 36 months | Yes | No |

\* Attach a schedule for the resident which includes the length, location, and date for each scheduled rotation.