**A picture containing text, clipart

Description automatically generated**

11400 Rockville Pike, Suite 200

Rockville, Maryland 20852

[CPMEStaff@cpme.org](mailto:CPMEStaff@cpme.org)

[www.cpme.org](http://www.cpme.org/)

**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, along with a block training schedule for the resident which includes the length, location, and date for each scheduled rotation for the remainder of their time in your program.

|  |  |  |  |
| --- | --- | --- | --- |
| **Receiving Institution Information** | | | |
| Name of Institution |  | | |
| Name of program director |  | | |
| Date of submission of this form |  | | |
| Name of resident |  | | |
| Transfer into which training year? (PGY1, PGY2, PGY3) |  | | |
| 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** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 transfer fee must be received from the receiving 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, additional fees apply. [Residency Fees are posted on the CPME website](https://www.cpme.org/files/CPME/2022-10_Residency_Fees.pdf).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Complete the following chart about the rotations completed and scheduled***  ***for residents that started training after July 1, 2023.*** | | | | | |
| **Rotation** | **Minimum**  **Length+** | **DATES COMPLETED**  **at/assessed by the Releasing Institution** | **FUTURE DATES**  **Scheduled during remainder of training\*** | | |
| **Required Rotations:** | | | | | |
| Anesthesiology | 2 weeks |  |  | | |
| Behavioral Sciences | 2 weeks |  |  | | |
| Emergency Medicine | 4 weeks |  |  | | |
| Medical Imaging | 2 weeks |  |  | | |
| **Medical Specialty Rotations – minimum requirement of 12 cumulative weeks of training** | | | | | |
| Internal/Family Medicine (required) | 4 weeks |  |  | | |
| Infectious Disease (required) | 2 weeks |  |  | | |
| **Medical specialty rotations – training must include at least *two* of the following:** | | | | | |
| Burn Unit | 2 weeks |  |  | | |
| Dermatology | 2 weeks |  |  | | |
| Endocrinology | 2 weeks |  |  | | |
| Geriatrics | 2 weeks |  |  | | |
| Intensive/Critical Care | 2 weeks |  |  | | |
| Neurology | 2 weeks |  |  | | |
| Pain Management | 2 weeks |  |  | | |
| Pediatrics | 2 weeks |  |  | | |
| Physical Medicine and Rehabilitation | 2 weeks |  |  | | |
| Rheumatology | 2 weeks |  |  | | |
| Wound Care | 2 weeks |  |  | | |
| Vascular Medicine | 2 weeks |  |  | | |
| Medical Specialty Rotations - minimum requirement of 12 cumulative weeks of training in medical specialties, including required rotations in Internal/Family Medicine and Infectious Disease. | | | | Yes | No |
| **Surgical Specialty Rotations – minimum requirement of 8 cumulative weeks of training.**  **Training must include *two* of the following:** | | | | | |
| Endovascular/Vascular (required) | 2 weeks |  |  | | |
| Cardiothoracic surgery | 2 weeks |  |  | | |
| General surgery | 2 weeks |  |  | | |
| Hand surgery | 2 weeks |  |  | | |
| Orthopedic surgery | 2 weeks |  |  | | |
| Neurosurgery | 2 weeks |  |  | | |
| Orthopedic/surgical oncology | 2 weeks |  |  | | |
| Pediatric orthopedic surgery | 2 weeks |  |  | | |
| Plastic surgery | 2 weeks |  |  | | |
| Surgical intensive care unit (SICU) | 2 weeks |  |  | | |
| Trauma team/surgery | 2 weeks |  |  | | |
| **Other rotations:** | | | | | |
|  | 2 weeks |  |  | | |
|  | 2 weeks |  |  | | |
| Surgical Specialty Rotations - minimum requirement of 8 cumulative weeks of training in surgical specialties, including required rotation in Endovascular/Vascular Surgery. | | | | Yes | No |

\*Please include a block training schedule for the resident which includes the length, location, and date for each scheduled rotation for the remainder of their time in your program.

By signing this form, the program director attests that they have reviewed all completed rotation assessments from the releasing Institution.

**Signatures Required**

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

Chief administrative officer (or DIO) Date

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

Chief administrative officer of co–sponsoring institution (if applicable) Date

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

Program director Date