ELECTIVE ROTATION IN PUBLIC HEALTH
Letter of Agreement

Name of Resident

Residency Program

Date of Planned Rotation

Directions: **Program Director:** Please sign where indicated, retain a copy for your records, and forward a scanned PDF of the original to the Public Health Rotation Supervisor.

Public Health Supervisor: Please print and sign the scanned original, retain a copy for your records, and forward a scanned PDF with both signatures to: FamilyPractice@THECB.state.tx.us

I, the undersigned, hereby certify that the resident participating in this rotation is in good standing in my program. I also certify that the resident has appropriate liability insurance coverage for training activities that will occur during this rotation. I also agree to abide by the attached Guidelines for Elective Rotation in Public Health, which I have read and understand.

_____ _____

Signature of Program Director Date

I, the undersigned, hereby certify that I will supervise this resident on his/her Elective Rotation in Public Health. I also certify that I will submit all required evaluations and that I will not encourage or knowingly permit any activities that could endanger the resident's board eligibility, including permitting unsupervised patient care. I also agree to abide by the attached Guidelines for Elective Rotation in Public Health, which I have read and understand.

_____ _____

Signature of Supervisor Date