

INFORMATION NEEDED FOR A NATIONAL CAPITAL CONSORTIUM AGREEMENT

- The name of the GME program involved (e.g., Internal Medicine Residency, Forensic Psychiatry Fellowship)
- The full name, medical degree, and military rank, service, and corps of the applicable program director.
- The applicable Program Director's mailing address, commercial telephone number, and e-mail address.
- The complete name of the institution with which an agreement is being requested.
- The complete address, including zip code, of that institution.
- The full name, academic/medical degrees (if any), and military rank (if applicable) of the person at the institution with whom you have arranged this rotation (the point of contact).
- The complete address, including zip code, of your point of contact at the institution.
- The commercial telephone number (not DSN) of your point of contact at the institution.
- The point of contact's e-mail address (essential).

If the agreement requested is a one-time agreement (for one physician's individual training experience), then also please provide:

- The Resident's or Fellow's complete name, medical degree, and military rank, service, and corps.
- The dates of the Resident's or Fellow's proposed training (e.g., 22 Nov - 19 Dec 2007).

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