GME Mission, Vision, Values
Graduate Medical Education Office
UTHSCSA

Our Mission

Our mission is to improve healthcare by advancing the quality of resident physicians' education.

Our Vision

Our vision is to foster growth of exemplary physicians, GME programs, and institutional practices.

Our Values

- Develop and share new knowledge
- Employ processes that are fair, transparent, and resource-conscious
- Maintain service-orientation and accountability
The GME Office and Your Program
Graduate Medical Education
The Relationship to the Sponsored Programs

- ACGME accredited programs must function under the authority and control of one Sponsoring Institution.
- Sponsoring Institution must:
  - Provide graduate medical education that facilitates professional, ethical, and personal development of the residents in the sponsored programs.
  - Support safe and appropriate patient care through the curriculum, evaluation, and supervision of residents.
- Designated Institutional Official (DIO) and Graduate Medical Education Committee (GMEC):
  - Oversight and administration of programs.
  - Responsible for ensuring compliance with ACGME Common, Specialty/Subspecialty-specific Program, and Institutional Requirements.
    - Reviews and co-sign all program information forms (PIFs) and any other documents or correspondence submitted by program directors to the ACGME.
    - Develop, implement, and oversee an internal review process (IR IV.)
  - Ensure program letters of agreement (PLAs) are established by programs for each educational (rotation) site.
  - Responsibility to residents to ensure:
    - Eligibility for appointment – meet the ACGME requirements
    - Selection of residents is based on program-related criteria and does not discriminate.
    - Financial support and benefits.
    - Applicants invited to interview are informed in writing, paper or electronically, of the terms, conditions and benefits of their appointment.
    - Implement, monitor, ensure adherence, and provide a written agreement/contract (to the residents) that outlines the terms and conditions of appointment to a program (IR II.D.1-4)
  - Monitor the reduction in size or closure of a program.
  - Cannot require residents to sign a non-competition guarantee.
- Educational and Professional Activities
  - Educational experience leads to measurable outcomes in the ACGME competencies
  - Ensure residents participate on committees and councils that affect their education and/or patient care.
  - Ensure residents’ educational programs include physician impairment, including substance abuse and sleep deprivation.
- Educational and Work Environment
  - Raise and resolve issues without fear of intimidation or retaliation.
  - Provide services and healthcare delivery systems to minimize residents’ work that is extraneous to the program’s goals and objectives.
  - Ensure a healthy and safe working environment that provides food service, call rooms, and security and safety.
- GMEC is responsible for establishing and implementing policies and procedures regarding the quality of the education and work environment of all residents in all programs.
Responsibilities of Graduate Medical Education Program Administration

| Purpose | Administration of the GME training program is a collaborative responsibility, led by the Program Director (GME Policy 4.1) and assisted by one or more Assistant/Associate Program Directors, faculty members, Program Coordinator(s), and other administrative staff as applicable. Those individuals tasked with day-to-day administration of the program (most often the PC) must be knowledgeable about important aspects of GME. This policy serves as guidance to programs regarding GME administrative responsibilities. |
| Policy | The GME Committee recognizes that the following areas of responsibility are required administrative processes of each GME program. Some program administration functions may be performed by members of a program's leadership team other than the Program Coordinator, however all of the following are required administrative responsibilities of each GME program (all are important; those critical to GME program functions are marked 'critical'). |

1. **Resident Selection, Support, and Documentation**
   - Coordinates the resident recruitment and selection process
   - Manages annual residency recruiting activities
     - Scheduling of candidates
     - Logistics of interview days
     - Document preparation
     - Communication during interview season
   - Ensures that residents are eligible for training per GME Policy 4.3 - Resident Selection and Appointment
| o Submits Security Background Checks to UT Police immediately following Match (or after interviews if program chooses) *critical* |
| o Submits TMB spreadsheet for PIT Permits *critical* |
| o OIS/ECFMG Visa Compliance by OIS deadlines (if applicable) *critical* |
| o Coordinates for all new residents (as applicable): |
|   ▪ UT Badge/access for participating sites |
| o Tracks and ensures timely completion of new resident Onboarding items |
| o Assists incoming trainees with in-processing activities and transition to residency (e.g., Sunrise scheduling, EPIC, BLS training, etc.) |
| o Prepares and plans orientation week schedules, training, and, if applicable, program-sponsored social activities |
| o Trains new residents and faculty on use of Ni, or facilitates training |
| o Coordinates the planning and preparation of the annual graduation event |
| o Ensures completion of resident check out (whether for termination, withdrawal, or graduation) |
| o Communicates resident change in status (probation, termination, withdrawal, etc.) to TMB and respective boards *critical* |
| o Coordinates gathering of procedure logs and final program letter of completion for graduating residents’ training files |
| o Ensures appropriate board eligibility or certification for specialty or subspecialty |
| o Arranges travel for resident conferences |
| o Processes reimbursement vouchers for resident travel, book allowance purchases, etc. |
| o Obtains and disseminates meal cards for residents on service |
| o Prepares documentation for ranking meeting |
2. Information Management

- Required NI Items Entered in a timely manner "critical"
  - Enters required demographics for incoming residents to include:
    - UTHSCSA email address
    - Pager/Cell number
    - NPI
    - Permit or license number
    - Local home address
  - Enters "payroll" information each year for all residents consistent with training contracts
  - Enters rotation block schedules by 7/1 for the following academic year and makes updates as necessary
  - Tracks/monitors duty hour entry and responds promptly to GME requests for program responses to violations
  - Maintains Procedure Logger in Ni for visibility of trainees' independence in performing bedside procedures
- Enters call and clinic schedules (in Ni or outside of Ni)
- Creates and updates evaluation forms (in Ni or outside of Ni)
- Creates and maintains conference attendance records (in Ni or outside of Ni)
- Disseminates curricular goals and objectives (in Ni or outside of Ni)
- Tracks license and certification expiration dates (in Ni or outside of Ni)
- Creates/distributes/monitors/maintains evaluations (in Ni or outside of Ni)
- Resident Evaluation of Rotation
- Faculty Evaluation of Residents
- Resident Evaluation of Faculty
- Resident Evaluation of Program
- Faculty Evaluation of Program
- Multi-source evaluations of residents, e.g., patient evaluations, peer evaluations, self-evaluations, evaluation by ancillary staff or administrative staff
- Summative Evaluation by PD
  - Monitors evaluation completion rates
  - Makes AAMC GME Track/FREIDA Updates (if applicable)
  - ERAS – sets-up and obtains applications and marks matched applicants as “Will Start” (if applicable)
  - Meets all NRMP (or other match) deadlines*critical*
    - Registering for Match (if applicable)
    - Registering for SOAP (if applicable)
    - Submits NRMP (or other match) Quotas and Rank Order Lists by deadline
  - Assembles and maintains residency files for trainees
    - Obtains appropriate documentation for Transfer Resident Files (if applicable)
  - Tracks Board scores for graduates
  - Collects and maintains forwarding information for graduates
    - Completes training verification processes for past graduates

3. Program Processes and Documentation
   - Program Letters of Agreement fully executed and within 3 years old
   - Guidance to residents - program and GME policies, scheduling, non-clinical aspects of the program
   - Monitors completion of required KC training by residents
   - Monitors completion of ELM Risk Management (RM) annual 5 hours of training for residents
Adheres to records retention schedule for all GME documents, including training files, formative evaluations, procedure logs, etc.
Coordinates, schedules, monitors in-training exam schedule (if applicable)
Coordinates required and elective rotations for residents outside of their specialty (e.g. Internal Medicine rotates through Neurology)
Completes Liability Enrollment for residents for coverage to begin on first day of residency
Ensures proper stipend allotment and funding splits for residents based on program’s funding availability
Tracks expenses and monitors budget for training program

4. ACGME Accreditation and Communication
   o ACGME Annual Update *critical*
     ▪ Enters/maintains information in ADS including:
       □ Major Changes
       □ Participating Sites
       □ Faculty/Teaching Staff
       □ Physician Faculty Roster
       □ Non-Physician Faculty Roster
       □ Program Director (Physician) CV
       □ Faculty Scholarly Activity
       □ Non-Physician CV
       □ Actively Enrolled Resident List
       □ Resident Scholarly Activity
       □ List of Residents on Leave
       □ Transferred, Withdrawn, and Dismissed Residents
       □ Evaluation Section
       □ Duty Hour, Patient Safety and Learning Environment Section
       □ PD changes (if applicable)
Requests for complement increase (if applicable)

Timely submission of information requested at annual roll-over

- Coordinates accreditation activities such as ACGME Site Visits, Periodic Program Reviews, Special Program Reviews, etc. *critical*
- Annual Program Evaluation (APE) - prepares, collects, and organizes documents and assists the PD in monitoring/implementing action plans *critical*
- Schedules and prepares documentation for Semi-Annual evaluations/Milestones
- Coordinates educational activities (e.g., didactic conference schedule, Grand Rounds, etc.) that support the program’s curriculum and adhere to ACGME and institutional requirements
- Monitors ACGME Case Logs for completion (if applicable)
- Coordinates/facilitates annual meetings with faculty, residents, and site directors for
  - Program Evaluation Committee
  - Clinical Competency Committee
  - Faculty Development
- Enters Milestones by deadline into ADS for each resident *critical*
- Notifies residents and faculty to complete and monitors ACGME Resident Survey and ACGME Faculty Survey for completion
- Provides GME Office with all information requested for CLER in a timely manner
- Assists the PD and faculty in tracking resident/fellow scholarly activity

5. Institutional GME Engagement - Responsiveness to GME, Paymaster, and Participating Sites
o Timely reporting of trainee leave/LOAs/training extensions/departures to GME office and participating sites
  *critical*
  
o GME Policies and Procedures and related departmental policies – current knowledge
  
o GME Audit Timeliness
  
o GME Audit Accuracy
  
o Participation in GMEC
  
o Participation in GMEC Program Coordinators Subcommittee
  
o Responsiveness to Requests from GME Office
  
o Responsiveness to Requests from UHS
    ▪ Prepares UH Alpha, Funding, Incoming, Renewing, Switching Specialties, Switching Funding, and Departing forms in a timely manner
  
o Responsiveness to Requests from VA
  
o Maintains and provides rotation breakdowns annually, and in the event of changes in rotation structure
  
o Notifies GME Office of quota changes, supplying all pertinent information
  
o Disseminates GME Post-Match Survey in a timely manner
  
o Ensures timely request of graduation certificates from GME Office
  
o Assists trainees in obtaining fully executed GME Contracts and any revisions of contracts necessary
  
o Submission of complete rotator/observer packets to GME office by published deadline
Hospitals and Other Sites
Relationships with Hospitals

University Hospital (University Health System, “UHS,” “UH”)

University Hospital of the University Health System is our major teaching hospital and paymaster for residents (with few exceptions).

They provide:

- Paychecks to residents
- Benefits to residents – vacation/sick, medical and dental insurance
- Resident contracts
- Some fees such as annual ACGME registration fees for programs
- Pagers for the majority of residents
- They provide salary lines for the majority of our residents

Contacts in Professional Staff Services

- Marilyn Dahl – 210-358-0062
- Adelfa Diaz – 210-358-0163

VA – South Texas Veteran’s Health Care System (Audie L. Murphy Hospital)

The VA is the second largest funding source for resident stipends (approximately 200 salary lines). UH invoices the VA for the salaries they provide.

Contacts in the Education Office: 210-617-5109

- Robin Risemas
- Cynthia Vahle
- David Dooley, MD, Associate Chief of Staff for Education

Methodist Healthcare System

Methodist is an additional provider of funds for certain programs. UH invoices them for the salaries they provide.

Contact in the Methodist GME Office:

- Michelle LeJeune – 210-575-4272

Baptist Health System

Baptist is an additional provider of funds for certain programs. UH invoices them for the salaries they provide.

Contact in the Medical Staff Services Office:

- Theresa Kirkpatrick – 210-297-8266
ACGME Institutional Requirements
ACGME

Institutional Requirements

ACGME approved: June 9, 2013; Effective: July 1, 2013 for new sponsoring institutions making new applications and July 1, 2014 for existing sponsoring institutions (including both multiple- and single- program sponsors)
ACGME approved focused revision: September 28, 2014; effective: July 1, 2015
ACGME Institutional Requirements

I. Structure for Educational Oversight

I.A. Sponsoring Institution

I.A.1. Residency and fellowship programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) must function under the ultimate authority and oversight of one Sponsoring Institution. Oversight of resident/fellow assignments and of the quality of the learning and working environment by the Sponsoring Institution extends to all participating sites. (Core)*

I.A.2. The Sponsoring Institution must be in substantial compliance with the ACGME Institutional Requirements and must ensure that each of its ACGME-accredited programs is in substantial compliance with the ACGME Institutional, Common, and specialty/subspecialty-specific Program Requirements, as well as with ACGME Policies and Procedures. (Outcome)

I.A.3. The Sponsoring Institution must maintain its ACGME institutional accreditation. Failure to do so will result in loss of accreditation for its ACGME-accredited program(s). (Outcome)

I.A.4. The Sponsoring Institution and each of its ACGME-accredited programs must only assign residents/fellows to learning and working environments that facilitate patient safety and health care quality. (Outcome)

I.A.5. The Sponsoring Institution must identify a:

I.A.5.a) Designated Institutional Official (DIO): The individual who, in collaboration with a Graduate Medical Education Committee (GMEC), must have authority and responsibility for the oversight and administration of each of the Sponsoring Institution’s ACGME-accredited programs, as well as for ensuring compliance with the ACGME Institutional, Common, and specialty/subspecialty-specific Program Requirements; and, (Core)

I.A.5.b) Governing Body: The entity which maintains authority over the Sponsoring Institution and each of its ACGME-accredited programs. (Core)

I.A.6. A written statement must document the Sponsoring Institution’s commitment to GME by providing the necessary financial support for administrative, educational, and clinical resources, including personnel, and which must be reviewed, dated, and signed at least once every five years by the DIO, a representative of the Sponsoring Institution’s senior administration, and a representative of the Governing Body. (Core)

I.A.7. Any Sponsoring Institution or participating site that is a hospital must maintain accreditation to provide patient care. (Core)
I.A.7.a) Accreditation for patient care must be provided by:

I.A.7.a).(1) the Joint Commission; or, (Core)

I.A.7.a).(2) an entity granted "deeming authority" for participation in Medicare under federal regulations; or, (Core)

I.A.7.a).(3) an entity certified as complying with the conditions of participation in Medicare under federal regulations. (Core)

I.A.8. When a Sponsoring Institution or major participating site that is a hospital loses its accreditation for patient care, the Sponsoring Institution must notify and provide a plan for its response to the Institutional Review Committee (IRC) within 30 days of such loss. Based on the particular circumstances, the IRC may request the ACGME invoke its "Procedure for Alleged Egregious or Catastrophic Events" policy. (Core)

I.A.9. When a Sponsoring Institution's or participating site's license is denied, suspended, or revoked, or when a Sponsoring Institution or participating site is required to curtail activities, or is otherwise restricted, the Sponsoring Institution must notify and provide a plan for its response to the IRC within 30 days of such loss or restriction. Based on the particular circumstances, the IRC may request that the ACGME invoke its "Procedure for Alleged Egregious or Catastrophic Events" policy. (Core)

I.B. GMEC

I.B.1. Membership

I.B.1.a) A Sponsoring Institution with multiple ACGME-accredited programs must have a GMEC that includes at least the following voting members: (Core)

I.B.1.a).(1) the DIO; (Core)

I.B.1.a).(2) a representative sample of program directors (minimum of two) from its ACGME-accredited programs; (Core)

I.B.1.a).(3) a minimum of two peer-selected residents/fellows from among its ACGME-accredited programs; and, (Core)

I.B.1.a).(4) a quality improvement or patient safety officer or designee. (Core)

I.B.1.b) A Sponsoring Institution with one program must have a GMEC that includes at least the following voting members:

I.B.1.b).(1) the DIO; (Core)

I.B.1.b).(2) the program director when the program director is not the
I.B.1.b).(3) a minimum of two peer-selected residents/fellows from its ACGME-accredited program or the only resident/fellow if the program includes only one resident/fellow; (Core)

I.B.1.b).(4) the individual or designee responsible for monitoring quality improvement or patient safety if this individual is not the DIO or program director; and, (Core)

I.B.1.b).(5) one or more individuals from a different department than that of the program specialty (and other than the quality improvement or patient safety member), within or from outside the Sponsoring Institution, at least one of whom is actively involved in graduate medical education. (Core)

I.B.2. Additional GMEC members and subcommittees: In order to carry out portions of the GMEC’s responsibilities, additional GMEC membership may include others as determined by the GMEC. (Detail)

I.B.2.a) Subcommittees that address required GMEC responsibilities must include a peer-selected resident/fellow. (Detail)

I.B.2.b) Subcommittee actions that address required GMEC responsibilities must be reviewed and approved by the GMEC. (Detail)

I.B.3. Meetings and Attendance: The GMEC must meet a minimum of once every quarter during each academic year. (Core)

I.B.3.a) Each meeting of the GMEC must include attendance by at least one resident/fellow member. (Core)

I.B.3.b) The GMEC must maintain meeting minutes that document execution of all required GMEC functions and responsibilities. (Core)

I.B.4. Responsibilities: GMEC responsibilities must include:

I.B.4.a) Oversight of:

I.B.4.a).(1) the ACGME accreditation status of the Sponsoring Institution and each of its ACGME-accredited programs; (Outcome)

I.B.4.a).(2) the quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites; (Outcome)

I.B.4.a).(3) the quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME
Common and specialty/subspecialty-specific Program Requirements; (Outcome)

I.B.4.a).(4) the ACGME-accredited program(s)' annual evaluation and improvement activities; and, (Core)

I.B.4.a).(5) all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution. (Core)

I.B.4.b) review and approval of:

I.B.4.b).(1) institutional GME policies and procedures; (Core)

I.B.4.b).(2) annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits; (Core)

I.B.4.b).(3) applications for ACGME accreditation of new programs; (Core)

I.B.4.b).(4) requests for permanent changes in resident/fellow complement; (Core)

I.B.4.b).(5) major changes in each of its ACGME-accredited programs' structure or duration of education; (Core)

I.B.4.b).(6) additions and deletions of each of its ACGME-accredited programs' participating sites; (Core)

I.B.4.b).(7) appointment of new program directors; (Core)

I.B.4.b).(8) progress reports requested by a Review Committee; (Core)

I.B.4.b).(9) responses to Clinical Learning Environment Review (CLER) reports; (Core)

I.B.4.b).(10) requests for exceptions to duty hour requirements; (Core)

I.B.4.b).(11) voluntary withdrawal of ACGME program accreditation; (Core)

I.B.4.b).(12) requests for appeal of an adverse action by a Review Committee; and, (Core)

I.B.4.b).(13) appeal presentations to an ACGME Appeals Panel. (Core)

I.B.5. The GMEC must demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR). (Outcome)

Institutional Requirements 5
I.B.5.a) The GMEC must identify institutional performance indicators for the AIR, which include:

I.B.5.a).(1) results of the most recent institutional self-study visit; (Detail)

I.B.5.a).(2) results of ACGME surveys of residents/fellows and core faculty members; and, (Detail)

I.B.5.a).(3) notification of each of its ACGME-accredited programs’ accreditation statuses and self-study visits. (Detail)

I.B.5.b) The AIR must include monitoring procedures for action plans resulting from the review. (Core)

I.B.5.c) The DIO must submit a written annual executive summary of the AIR to the Governing Body. (Core)

I.B.6. The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process. (Core)

I.B.6.a) The Special Review process must include a protocol that:

I.B.6.a).(1) establishes criteria for identifying underperformance; and, (Core)

I.B.6.a).(2) results in a report that describes the quality improvement goals, the corrective actions, and the process for GME monitoring of outcomes. (Core)

II. Institutional Resources

II.A. Institutional GME Infrastructure and Operations: The Sponsoring Institution must ensure that:

II.A.1. the DIO has sufficient financial support and protected time to effectively carry out his or her educational, administrative, and leadership responsibilities; (Core)

II.A.2. the DIO engages in professional development applicable to his or her responsibilities as an educational leader; and, (Core)

II.A.3. sufficient salary support and resources are provided for effective GME administration. (Core)

II.B. Program Administration: The Sponsoring Institution, in collaboration with each ACGME-accredited program, must ensure that:

II.B.1. the program director(s) has (have) sufficient financial support and protected time to effectively carry out his/her (their) educational, administrative, and leadership responsibilities, as described in the Institutional, Common, and specialty/subspecialty-specific Program
II.B.2. the program(s) receives (receive) adequate support for core faculty members to ensure both effective supervision and quality resident/fellow education;  
( Core)  
II.B.3. the program director(s) and core faculty members engage in professional development applicable to their responsibilities as educational leaders;  
( Core)  
II.B.4. the program coordinator(s) has (have) sufficient support and time to effectively carry out his/her (their) responsibilities; and,  
( Core)  
II.B.5. resources, including space, technology, and supplies, are available to provide effective support for each of its ACGME-accredited programs.  
( Core)  
II.C. Resident/Fellow Forum: The Sponsoring Institution with more than one program must ensure availability of an organization, council, town hall, or other platform that allows residents/fellows from within and across the Sponsoring Institution’s ACGME-accredited programs to communicate and exchange information with each other relevant to their ACGME-accredited programs and their learning and working environment.  
( Core)  
II.C.1. Any resident/fellow from one of the Sponsoring Institution’s ACGME-accredited programs must have the opportunity to raise a concern to the forum.  
( Core)  
II.C.2. Residents/fellows must have the option, at least in part, to conduct their forum without the DIO, faculty members, or other administrators present.  
( Core)  
II.C.3. Residents/fellows must have the option to present concerns that arise from discussions at the forum to the DIO and GMEC.  
( Core)  
II.D. Resident Salary and Benefits: The Sponsoring Institution, in collaboration with each of its ACGME-accredited programs and participating sites, must provide all residents/fellows with financial support and benefits to ensure that they are able to fulfill the responsibilities of their ACGME-accredited program(s).  
( Core)  
II.E. Educational Tools  
II.E.1. Communication resources and technology: Faculty members and residents/fellows must have ready access to adequate communication resources and technological support.  
( Core)  
II.E.2. Access to medical literature: Faculty members and residents/fellows must have ready access to specialty/subspecialty-specific electronic medical literature databases and other current reference material in print or electronic format.  
( Core)
II.F.  Support Services and Systems

II.F.1.  The Sponsoring Institution must provide support services and develop health care delivery systems to minimize residents'/fellows' work that is extraneous to their ACGME-accredited program(s)' educational goals and objectives, and to ensure that residents'/fellows' educational experience is not compromised by excessive reliance on residents/fellows to fulfill non-physician service obligations. These support services and systems must include:  

II.F.1.a)  peripheral intravenous access placement, phlebotomy, laboratory, pathology and radiology services and patient transportation services provided in a manner appropriate to and consistent with educational objectives and to support high quality and safe patient care; and,  

II.F.1.b)  medical records available at all participating sites to support high quality and safe patient care, residents'/fellows' education, quality improvement and scholarly activities.  

II.F.2.  The Sponsoring Institution must ensure a healthy and safe learning and working environment that provides for:

II.F.2.a)  access to food while on duty at all participating sites;  

II.F.2.b)  safe, quiet, and private sleep/rest facilities available and accessible for residents/fellows to support education and safe patient care; and,  

II.F.2.c)  security and safety measures appropriate to the participating site.  

III.  Resident/Fellow Learning and Working Environment

III.A.  The Sponsoring Institution and each of its ACGME-accredited programs must provide a learning and working environment in which residents/fellows have the opportunity to raise concerns and provide feedback without intimidation or retaliation and in a confidential manner as appropriate.  

III.B.  The Sponsoring Institution is responsible for oversight and documentation of resident/fellow engagement in the following:  

III.B.1.  Patient Safety: The Sponsoring Institution must ensure that residents/fellows have:

III.B.1.a)  access to systems for reporting errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal; and,  

III.B.1.b)  opportunities to contribute to root cause analysis or other similar risk-reduction processes.  

Institutional Requirements 8
III.B.2. Quality Improvement: The Sponsoring Institution must ensure that residents/fellows have:

III.B.2.a) access to data to improve systems of care, reduce health care disparities, and improve patient outcomes; and, (Core)

III.B.2.b) opportunities to participate in quality improvement initiatives. (Core)

III.B.3. Transitions of Care: The Sponsoring Institution must:

III.B.3.a) facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care; and, (Core)

III.B.3.b) ensure that participating sites engage residents/fellows in standardized transitions of care consistent with the setting and type of patient care. (Core)

III.B.4. Supervision: The Sponsoring Institution must oversee:

III.B.4.a) supervision of residents/fellows consistent with institutional and program-specific policies; and, (Core)

III.B.4.b) mechanisms by which residents/fellows can report inadequate supervision in a protected manner that is free from reprisal. (Core)

III.B.5. Duty Hours, Fatigue Management, and Mitigation: The Sponsoring Institution must oversee:

III.B.5.a) resident/fellow duty hours consistent with the Common and specialty/subspecialty-specific Program Requirements across all programs, addressing areas of non-compliance in a timely manner; (Core)

III.B.5.b) systems of care and learning and working environments that facilitate fatiguer management and mitigation for residents/fellows; and, (Core)

III.B.5.c) an educational program for residents/fellows and core faculty members in fatigue management and mitigation. (Core)

III.B.6. Professionalism: The Sponsoring Institution must provide systems for education in and monitoring of:

III.B.6.a) residents' fellows' and core faculty members' fulfillment of educational and professional responsibilities, including scholarly pursuits; (Core)

III.B.6.b) accurate completion of required documentation by residents/fellows; and, (Core)
III.B.6.c) identification of resident/fellow mistreatment. (Core)

IV. Institutional GME Policies and Procedures

IV.A. Resident/Fellow Recruitment

IV.A.1. Eligibility and Selection of Residents/Fellows: The Sponsoring Institution must have written policies and procedures for resident/fellow recruitment and appointment, and must monitor each of its ACGME-accredited programs for compliance. (Core)

IV.A.2. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)

IV.A.2.a) graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or, (Core)

IV.A.2.b) graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association (AOA); or, (Core)

IV.A.2.c) graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core)

IV.A.2.c.(1) holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or, (Core)

IV.A.2.c.(2) holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty/subspecialty program; or, (Core)

IV.A.2.c.(3) has graduated from a medical school outside the United States and has completed a Fifth Pathway** program provided by an LCME-accredited medical school. (Core)

IV.A.3. An applicant invited to interview for a resident/fellow position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment. (Core)

IV.A.3.a) Information that is provided must include: financial support; vacations; parental, sick, and other leaves of absence; and professional liability, hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents. (Core)

IV.B. Agreement of Appointment/Contract

Institutional Requirements 10
IV.B.1. The Sponsoring Institution must ensure that residents/fellows are provided with a written agreement of appointment/contract outlining the terms and conditions of their appointment to a program. The Sponsoring Institution must monitor each of its programs with regard to implementation of terms and conditions of appointment. (Core)

IV.B.2. The contract/agreement of appointment must directly contain or provide a reference to the following items: (Core)

IV.B.2.a) resident/fellow responsibilities; (Core)

IV.B.2.b) duration of appointment; (Core)

IV.B.2.c) financial support for residents/fellows; (Core)

IV.B.2.d) conditions for reappointment and promotion to a subsequent PGY level; (Core)

IV.B.2.e) grievance and due process; (Core)

IV.B.2.f) professional liability insurance, including a summary of pertinent information regarding coverage; (Core)

IV.B.2.g) hospital and health insurance benefits for residents/fellows and their eligible dependents; (Core)

IV.B.2.h) disability insurance for residents/fellows; (Core)

IV.B.2.i) vacation, parental, sick, and other leave(s) for residents/fellows, compliant with applicable laws; (Core)

IV.B.2.j) timely notice of the effect of leave(s) on the ability of residents/fellows to satisfy requirements for program completion; (Core)

IV.B.2.k) information related to eligibility for specialty board examinations; and, (Core)

IV.B.2.l) institutional policies and procedures regarding resident/fellow duty hours and moonlighting. (Core)

IV.C. Promotion, Appointment Renewal and Dismissal

IV.C.1. The Sponsoring Institution must have a policy that requires each of its ACGME-accredited programs to determine the criteria for promotion and/or renewal of a resident/fellow's appointment. (Core)

IV.C.1.a) The Sponsoring Institution must ensure that each of its programs provides a resident/fellow with a written notice of intent when that resident's/fellow's agreement will not be renewed, when that
resident/fellow will not be promoted to the next level of training, or when that resident/fellow will be dismissed. (Core)

IV.C.1.b) The Sponsoring Institution must have a policy that provides residents/fellows with due process relating to the following actions regardless of when the action is taken during the appointment period: suspension, non-renewal, non-promotion; or dismissal. (Core)

IV.D. Grievances: The Sponsoring Institution must have a policy that outlines the procedures for submitting and processing resident/fellow grievances at the program and institutional level and that minimizes conflicts of interest. (Core)

IV.E. Professional Liability Insurance

IV.E.1. The Sponsoring Institution must provide residents/fellows with professional liability coverage, including legal defense and protection against awards from claims reported or filed during participation in each of its ACGME-accredited programs, or after completion of the program(s) if the alleged acts or omissions of a resident/fellow are within the scope of the program(s). (Core)

IV.E.2. The Sponsoring Institution must provide official documentation of the details of liability coverage upon request of the individual. (Core)

IV.F. Health and Disability Insurance

IV.F.1. The Sponsoring Institution must provide health insurance benefits for residents/fellows and their eligible dependents beginning on the first day of insurance eligibility. (Core)

IV.F.1.a) If the first day of health insurance eligibility is not the first day that residents/fellows are required to report, then the residents/fellows must be given advanced access to information regarding interim coverage so that they can purchase coverage if desired. (Core)

IV.F.2. The Sponsoring Institution must provide disability insurance benefits for residents/fellows beginning on the first day of disability insurance eligibility. (Core)

IV.F.2.a) If the first day of disability insurance eligibility is not the first day that residents/fellows are required to report, then the residents/fellows must be given advanced access to information regarding interim coverage so that they can purchase coverage if desired. (Core)

IV.G. Vacation and Leaves of Absence

IV.G.1. The Sponsoring Institution must have a policy for vacation and other leaves of absence, consistent with applicable laws. (Core)
IV.G.2. This policy must ensure that each of its ACGME-accredited programs provides its residents/fellows with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's/fellow's eligibility to participate in examinations by the relevant certifying board(s). (Core)

IV.H. Resident Services

IV.H.1. Behavioral Health: The Sponsoring Institution must provide residents/fellows with access to confidential counseling and behavioral health services. (Core)

IV.H.2. Physician Impairment: The Sponsoring Institution must have a policy, not necessarily GME-specific, which addresses physician impairment. (Core)

IV.H.3. Harassment: The Sponsoring Institution must have a policy, not necessarily GME-specific, covering sexual and other forms of harassment, that allows residents/fellows access to processes to raise and resolve complaints in a safe and non-punitive environment consistent with applicable laws and regulations. (Core)

IV.H.4. Accommodation for Disabilities: The Sponsoring Institution must have a policy, not necessarily GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations. (Core)

IV.I. Supervision

IV.I.1. The Sponsoring Institution must maintain an institutional policy regarding supervision of residents/fellows. (Core)

IV.I.2. The Sponsoring Institution must ensure that each of its ACGME-accredited programs establishes a written program-specific supervision policy consistent with the institutional policy and the respective ACGME Common and specialty/subspecialty-specific Program Requirements. (Core)

IV.J. Duty Hours: The Sponsoring Institution must maintain a duty hour policy that ensures effective oversight of institutional and program-level compliance with ACGME duty hour standards. (Core)

IV.J.1. Moonlighting: The Sponsoring Institution must maintain a policy on moonlighting that includes the following:

IV.J.1.a) residents/fellows must not be required to engage in moonlighting; (Core)

IV.J.1.b) residents/fellows must have written permission from their program director to moonlight; (Core)

IV.J.1.c) an ACGME-accredited program will monitor the effect of moonlighting activities on a resident's/fellow's performance in the program, including that adverse effects may lead to withdrawal of
permission to moonlight; and, \( \text{(Core)} \)

IV.J.1.d) the Sponsoring Institution or individual ACGME-accredited programs may prohibit moonlighting by residents/fellows. \( \text{(Core)} \)

IV.K. Vendors: The Sponsoring Institution must maintain a policy that addresses interactions between vendor representatives/corporations and residents/fellows and each of its ACGME-accredited programs. \( \text{(Core)} \)

IV.L. Non-competition: The Sponsoring Institution must maintain a policy which states that neither the Sponsoring Institution nor any of its ACGME-accredited programs will require a resident/fellow to sign a non-competition guarantee or restrictive covenant. \( \text{(Core)} \)

IV.M. Disasters: The Sponsoring Institution must maintain a policy consistent with ACGME Policies and Procedures that addresses administrative support for each of its ACGME-accredited programs and residents/fellows in the event of a disaster or interruption in patient care. \( \text{(Core)} \)

IV.M.1. This policy should include information about assistance for continuation of salary, benefits, and resident/fellow assignments. \( \text{(Core)} \)

IV.N. Closures and Reductions: The Sponsoring Institution must maintain a policy that addresses GMEC oversight of reductions in size or closure of each of its ACGME-accredited programs, or closure of the Sponsoring Institution that includes the following: \( \text{(Core)} \)

IV.N.1. the Sponsoring Institution must inform the GMEC, DIO, and affected residents/fellows as soon as possible when it intends to reduce the size of or close one or more ACGME-accredited programs, or when the Sponsoring Institution intends to close; and, \( \text{(Core)} \)

IV.N.2. the Sponsoring Institution must allow residents/fellows already in an affected ACGME-accredited program(s) to complete their education at the Sponsoring Institution, or assist them in enrolling in (an)other ACGME-accredited program(s) in which they can continue their education. \( \text{(Core)} \)

***

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

**Footnote for IV.A.2.c),(3): A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school; (2)
have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).
Common Program Requirements
ACGME
Common Program Requirements

ACGME approved major revision of Section VI: February, 2017; effective: July 1, 2017
Common Program Requirements

Note: The term “resident” in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms “resident” and “fellow” will be used respectively.

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. (Core)*

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. (Core)
The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents; (Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; (Detail)

I.B.1.c) specify the duration and content of the educational experience; and, (Detail)

I.B.1.d) state the policies and procedures that will govern resident education during the assignment. (Detail)

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). (Core)

[As further specified by the Review Committee]

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. (Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

[As further specified by the Review Committee]

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. (Detail)

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; (Core)

II.A.3.b) current certification in the specialty by the American Board of _____, or specialty qualifications that are acceptable to the Review Committee; and, (Core)

II.A.3.c) current medical licensure and appropriate medical staff appointment. (Core)
II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. (Core)

The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; (Core)

II.A.4.b) approve a local director at each participating site who is accountable for resident education; (Core)

II.A.4.c) approve the selection of program faculty as appropriate; (Core)

II.A.4.d) evaluate program faculty; (Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f) monitor resident supervision at all participating sites; (Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME. (Core)

II.A.4.g).(1) This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. (Core)

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; (Detail)

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion; (Detail)

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, (Core)

and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the residents and faculty; (Detail)

II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive
service demands and/or fatigue; and, {Detail}

II.A.4.j)(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue; {Detail}

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; {Detail}

II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents; {Detail}

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; {Detail}

II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: {Core}

II.A.4.n).(1) all applications for ACGME accreditation of new programs; {Detail}

II.A.4.n).(2) changes in resident complement; {Detail}

II.A.4.n).(3) major changes in program structure or length of training; {Detail}

II.A.4.n).(4) progress reports requested by the Review Committee; {Detail}

II.A.4.n).(5) requests for increases or any change to resident duty hours; {Detail}

II.A.4.n).(6) voluntary withdrawals of ACGME-accredited programs; {Detail}

II.A.4.n).(7) requests for appeal of an adverse action; and, {Detail}

II.A.4.n).(8) appeal presentations to a Board of Appeal or the ACGME. {Detail}

II.A.4.o) obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses; {Detail}

II.A.4.o).(1) program citations, and/or, {Detail}

II.A.4.o).(2) request for changes in the program that would have
significant impact, including financial, on the program or institution. (Detail)

[As further specified by the Review Committee]

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location. (Core)

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents; and, (Core)

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas. (Core)

II.B.2. The physician faculty must have current certification in the specialty by the American Board of ______, or possess qualifications judged acceptable to the Review Committee. (Core)

[As further specified by the Review Committee]

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; (Detail)

II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b).(4) participation in national committees or educational
II.B.5.c) Faculty should encourage and support residents in scholarly activities. *(Core)*

[As further specified by the Review Committee]

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. *(Core)*

[As further specified by the Review Committee]

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. *(Core)*

[As further specified by the Review Committee]

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. *(Detail)*

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. *(Core)*

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. *(Core)*

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1
level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. (Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC- accredited residency program located in Canada. (Core)

III.A.2.a) Fellowship programs must receive verification of each entering fellow’s level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. (Core)

III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: (Core)

III.A.2.b).(1) Assessment by the program director and fellowship selection committee of the applicant’s suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and (Core)

III.A.2.b).(2) Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GMEC; and (Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; (Core)
III.A.2.b).(4) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, (Core)

III.A.2.b).(5) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program. (Core)

III.A.2.b).(5).(a) If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. (Core)

** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.

[Each Review Committee will decide no later than December 31, 2013 whether the exception specified above will be permitted. If the Review Committee will not allow this exception, the program requirements will include the following statement]:

III.A.2.c) The Review Committee for ____ does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2. (Core)

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. (Core)

III.B.1. The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. (Core)

[As further specified by the Review Committee]
III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident. (Detail)

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion. (Detail)

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents’ education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

[As further specified by the Review Committee]

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must make available to residents and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and, (Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a)(1) Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

(Outcome)

[As further specified by the Review Committee]
IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: *(Outcome)*

[As further specified by the Review Committee]

IV.A.5.b) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents: *(Outcome)*

[As further specified by the Review Committee]

IV.A.5.c) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. *(Outcome)*

Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one’s knowledge and expertise; *(Outcome)*

IV.A.5.c).(2) set learning and improvement goals; *(Outcome)*

IV.A.5.c).(3) identify and perform appropriate learning activities; *(Outcome)*

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; *(Outcome)*

IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice; *(Outcome)*

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems; *(Outcome)*

IV.A.5.c).(7) use information technology to optimize learning; and,* *(Outcome)*

IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals. *(Outcome)*

[As further specified by the Review Committee]

IV.A.5.d) Interpersonal and Communication Skills
Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Residents are expected to:

- IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)
- IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health-related agencies; (Outcome)
- IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group; (Outcome)
- IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and, (Outcome)
- IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

[As further specified by the Review Committee]

**IV.A.5.e)** Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

- IV.A.5.e).(1) compassion, integrity, and respect for others; (Outcome)
- IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest; (Outcome)
- IV.A.5.e).(3) respect for patient privacy and autonomy; (Outcome)
- IV.A.5.e).(4) accountability to patients, society, and the profession; and, (Outcome)
- IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

[As further specified by the Review Committee]

**IV.A.5.f)** Systems-based Practice

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Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)

Residents are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems; (Outcome)

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions. (Outcome)

[As further specified by the Review Committee]

IV.B. Residents’ Scholarly Activities

IV.B.1. The curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.2. Residents should participate in scholarly activity. (Core)

[As further specified by the Review Committee]

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. (Detail)

[As further specified by the Review Committee]

V. Evaluation

V.A. Resident Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. (Core)
V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a). (1). (a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program’s residents in patient care and other health care settings. (Core)

V.A.1.a). (1). (b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. (Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

V.A.1.b). (1) The Clinical Competency Committee should:

V.A.1.b). (1). (a) review all resident evaluations semi-annually. (Core)

V.A.1.b). (1). (b) prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)

V.A.1.b). (1). (c) advise the program director regarding resident progress, including promotion, remediation, and dismissal. (Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. (Core)

V.A.2.b) The program must:

V.A.2.b). (1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; (Core)

V.A.2.b). (2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); (Detail)

V.A.2.b). (3) document progressive resident performance improvement
appropriate to educational level; and, (Core)

V.A.2.b).(4) provide each resident with documented semiannual
evaluation of performance with feedback. (Core)

V.A.2.c) The evaluations of resident performance must be accessible for
review by the resident, in accordance with institutional policy. (Detail)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools
to ensure residents are able to practice core professional activities
without supervision upon completion of the program. (Core)

V.A.3.b) The program director must provide a summative evaluation for
each resident upon completion of the program. (Core)

This evaluation must:

V.A.3.b).(1) become part of the resident’s permanent record
maintained by the institution, and must be accessible for
review by the resident in accordance with institutional
policy; (Detail)

V.A.3.b).(2) document the resident’s performance during the final
period of education; and, (Detail)

V.A.3.b).(3) verify that the resident has demonstrated sufficient
competence to enter practice without direct supervision.
(Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it
relates to the educational program. (Core)

V.B.2. These evaluations should include a review of the faculty’s clinical
teaching abilities, commitment to the educational program, clinical
knowledge, professionalism, and scholarly activities. (Detail)

V.B.3. This evaluation must include at least annual written confidential
evaluations by the residents. (Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee
(PEC). (Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty
members and should include at least one resident; (Core)
V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below. (Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. (Core)

The program must monitor and track each of the following areas:

V.C.2.a) resident performance; (Core)

V.C.2.b) faculty development; (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.d) program quality; and, (Core)

V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)

V.C.2.d).(2) The program must use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program. (Detail)

V.C.2.e) progress on the previous year’s action plan(s). (Core)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)
VI. The Learning and Working Environment

*Residency education must occur in the context of a learning and working environment that emphasizes the following principles:*

- **Excellence in the safety and quality of care rendered to patients by residents today**
- **Excellence in the safety and quality of care rendered to patients by today’s residents in their future practice**
- **Excellence in professionalism through faculty modeling of:**
  - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
  - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- **Commitment to the well-being of the students, residents, faculty members, and all members of the health care team**

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

*All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.*

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

*It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.*

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

*A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.*
VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1.a).(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution’s patient safety reports. (Core)

VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a).(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for
All residents must receive training in how to disclose adverse events to patients and families. (Core)

Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

Quality Improvement

Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

Residents must have the opportunity to participate in interprofessional quality improvement activities. (Core)

This should include activities aimed at reducing health care disparities. (Detail)

Supervision and Accountability

Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring...
Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)

VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

[The Review Committee may specify which activities require different levels of supervision.]

VI.A.2.c) Levels of Supervision

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision; (Core)

VI.A.2.c).(1) Direct Supervision – the supervising physician is physically
present with the resident and patient. (Core)

VI.A.2.c).(2) Indirect Supervision:

VI.A.2.c).(2).(a) with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)

VI.A.2.c).(2).(b) with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core)

VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)

VI.A.2.d).(1) The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

VI.A.2.e).(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

VI.A.2.e).(1).(a) Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents]
Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core)

VI.B.2.c) ensure manageable patient care responsibilities. (Core)

[As further specified by the Review Committee]

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

VI.B.4.c) assurance of their fitness for work, including:

VI.B.4.c.(1) management of their time before, during, and after clinical assignments; and, (Outcome)

VI.B.4.c.(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement
indicators; and, (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider. (Outcome)

VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

VI.C.1.d).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring
Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must:

VI.C.1.e),(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; 

VI.C.1.e),(2) provide access to appropriate tools for self-screening; and,

VI.C.1.e),(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

VI.D.2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue.

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who
may be too fatigued to safely return home.\textsuperscript{(Core)}

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services.\textsuperscript{(Core)}

[Optimal clinical workload may be further specified by each Review Committee.]

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system.\textsuperscript{(Core)}

[Each Review Committee will define the elements that must be present in each specialty.]

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.\textsuperscript{(Core)}

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.\textsuperscript{(Core)}

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process.\textsuperscript{(Outcome)}

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.\textsuperscript{(Core)}

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.\textsuperscript{(Core)}

VI.F. Clinical Experience and Education

\textit{Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable}
opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

VI.F.2.d) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a).(3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures. (Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)
VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

***

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.  
Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.  
Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.
International Medical Graduates
# UTHSCSA Graduate Medical Education Policies

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## Resident Visas

### Policy

The University of Texas Health Science Center (UTHSCSA) accepts international medical graduates who meet UTHSCSA eligibility and selection requirements and Texas Medical Board licensure requirements into its graduate medical education programs. All international medical graduates (IMGs) except for those who graduated from an accredited (LCME or CACMS) medical school in the United States or Canada must have a current and valid ECFMG (Educational Commission for Foreign Medical Graduates) certificate at the time of application.

This policy applies to applicants to and enrolled residents in **GME residency programs**. For applicants to and enrolled fellows in **GME fellowship programs**, please see GME Policy 2.14.b.

Individuals who are not United States citizens must have U.S. Lawful Permanent Resident status, asylee or refugee status, or must obtain a J-1 visa sponsored by ECFMG except if applicants qualify for the following narrow exception for **continued** H-1B visa sponsorship. [Individuals who hold an employment authorization document Form I-766 (including those in J-2 status but not those granted employment authorization because of asylee/refugee status) must be sponsored for an ECFMG J-1 visa. They cannot engage in the residency training program solely based upon the employment authorization document.] UTHSCSA only sponsors residents for H-1B visas when an applicant is currently on an H-1B visa engaged in graduate medical training at another institution in the U.S. and is eligible to have the H-1B status transferred and extended for the duration of the program.

The Designated Institutional Official may grant waivers, on a case by case basis, permitting individuals to engage in training on the basis of an employment authorization document upon a written request of the individual’s prospective program director.

If an applicant is unable to obtain the appropriate visa status (as described above – either ECFMG J-1 or H-1B status), regardless of the reason, participation in the residency program will not be permitted.
Foreign nationals applying for a J-1 exchange visitor visa must be eligible for visa sponsorship under the criteria set forth by the ECFMG. See the Selected Federal Regulations for J-1 Physicians for a list of key regulations for international medical graduates participating in clinical training programs on J-1 visas.

To be eligible to be sponsored for a H-1B visa, international medical graduates who did not graduate from an accredited medical school in the U.S. must have passed Parts 1, 2, and 3 of the U.S. Medical Licensing Examination (USMLE) and have a license or other authorization required by the Texas Medical Board to practice medicine. The applicant must meet all other legal requirements for H-1B status which the Office of International Services (OIS) will determine upon reviewing the applicant’s U.S. immigration documents and other relevant documents.

Administrative and financial costs associated with support of the H-1B visa are significant. The decision to financially support an H-1B visa will ultimately rest with the training program and the associated department. University Health System (UHS) will not serve as paymaster (provide salary or benefits) for an individual on an H-1B visa. Thus, the department will be responsible for paying the entire salary and benefits for fellows on H-1B visas in addition to the governmental filing and internal visa processing fees. Moreover, the U.S. Department of Labor determines the required wage for H-1B visas which may be more than the department initially intended to pay.

Requests for H-1B visa sponsorship of a prospective resident must be approved by the GME Office and the Office of International Services (OIS) prior to the program ranking the applicant on a match list or extending an offer for appointment to the applicant.

If an applicant’s situation falls under the exception defined above and a program director agrees to comply with the financial obligations and compliance requirements associated with H-1B visa sponsorship, the program director must submit a written Request for H-1B Sponsorship for GME to the OIS for initial review to determine if the request falls within the exception detailed above. Upon completing the initial review, the OIS will forward the request to the GME Office. The written request must be signed by the program director, department chair, individual applicant, and OIS director and must be made at least ninety (90) days before the applicant’s proposed date of appointment. The request will be reviewed by the Designated Institutional Official (DIO) or designee within ten (10) working days of its receipt by the GME Office and the DIO will communicate a decision to the program director. In the event of a negative decision by the DIO, the program director may appeal the decision to the GMEC at the next scheduled meeting. The GMEC shall be the final ruling body. Approval for the request will be for the duration of the proposed program only. The program director must await approval of the request before making a commitment to the applicant.
UTHSCSA Graduate Medical Education Policies

| UTHSCSA will not provide sponsorship of permanent residence for international medical graduates in GME training programs under any circumstances. |
Policy 2.14.1
September 2014

Request for H-1B Visa Sponsorship

Department/Program: Date of Request:
Name of Applicant: Degree:
Current U.S. Immigration Status: Proposed Stipend:
Date for Proposed Appointment to Program: PGY Level:
Medical School: Date of graduation:

Other GME training/dates (Do not list observations, research, and/or volunteer assignments.):

<table>
<thead>
<tr>
<th>Dates</th>
<th>Residency/Fellowship Training (program, institution)</th>
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Yes  No  Applicant has ECFMG certificate (required unless graduate of LCME or CACMS medical school).
Yes  No  ACGME accredited programs only: Applicant meets ACGME eligibility for the position.
Yes  No  Applicant is/will be Texas board-eligible to practice medicine by proposed start date.
Yes  No  Applicant has passed USMLE, Steps 1, 2, and 3.

Date of security background check: Result:
Date of interview for residency/fellowship position:
Names of interviewers:

Please attach copies of the applicant’s current U.S. immigration documents including approval notices for prior H-1B status. Request must be submitted to the Office of International Services (OIS) 3 to 6 months prior to applicant’s proposed date of appointment. Upon approval, OIS will forward the request to the GME Office. Please allow 10 business days processing time upon receipt of the request by the GME Office.

Attestations and Signatures

I, ____________________________, request a waiver of the GME Visa Policy requiring J-1 visa sponsorship for the above named physician because s/he is currently on an H-1B visa engaged in graduate medical training at another institution in the U.S. and is eligible to have the H-1B status transferred and extended for the duration of the program.

_________________________________________________________  ____________________________
Program Director Date

I, ____________________________, take responsibility for payment of the required wage as determined by the U.S. Department of Labor (including for participation in required orientation), benefits, return transportation, and visa filing fees for the above-named individual.

_________________________________________________________  ____________________________
Department Chair Date

Resident/Fellow Applicant  Date

Director, Office of International Services  Date

Designated Institutional Official  Date
Section 1 General Policies and Procedures

Policy 2.14.2 International Travel for Trainees on Visas

Effective: August 2012
Revised: July 2016
Responsibility: Designated Institutional Official

International Travel for Trainees on J-1 or H-1B Visas

Purpose The purpose of this policy is to establish guidelines for trainees on visas when traveling outside of the United States.

Policy The GME Committee recognizes that many trainees travel outside of the United States (U.S.). Trainees with visas may encounter unexpected delays when applying for visas abroad that prevent them from returning to academic responsibilities as scheduled. Trainees with visas must contact the Office of International Services (210-567-6241, international@uthscsa.edu) prior to making travel arrangements if leaving the U.S. during their training programs. For trainees on an ECFMG-sponsored J-1 visa, prior to departure a travel signature from ECFMG is required.

(Trainees who plan to travel abroad for any HSC-associated or sponsored business or academic purposes to countries that may fall under a U.S. Department of State Travel Warning must obtain approval from the International Oversight Committee of an International Travel to High Risk Areas Waiver well in advance of the planned travel date. Approval of the waiver request is not guaranteed. Please refer to HOP Chapter 15 for more information about travel to restricted regions.)

A trainee who is prevented from returning to the U.S. as scheduled due to unforeseen travel delays will continue to receive his/her stipend up to the remaining allotment of vacation. Once a trainee reaches the maximum allotment of vacation days, s/he will be required to take an unpaid leave of absence for the remainder of his/her time away. Benefit coverage will continue.

Additional circumstances of the continued absence may allow the trainee to be eligible for another type of leave (e.g. emergency leave/funerals, short-term disability).

Extended breaks in time during training may negatively impact board eligibility – see GME Policy 7.3.1.
In the case of an extended absence which is disruptive to other trainees within the program, the program director may elect to rescind the appointment and fill the position.
Fellow Visas

The University of Texas Health Science Center (UTHSCSA) accepts international medical graduates (IMGs) who meet UTHSCSA and ACGME eligibility and selection requirements and Texas Medical Board licensure requirements into its graduate medical education programs. All IMGs except for those who graduated from an accredited (LCME or CACMS) medical school in the United States or Canada must have a current and valid ECFMG (Educational Commission for Foreign Medical Graduates) certificate at the time of application. See [About ECFMG Certification](#) for information about the requirements to obtain an ECFMG certificate.

This policy applies to applicants to and enrolled fellows in GME fellowship programs. For applicants to and enrolled residents in GME residency programs, please see GME Policy 2.14.a.

Individuals who are not United States citizens must have U.S. Lawful Permanent Resident status, asylee or refugee status, or must obtain a J-1 visa sponsored by ECFMG or a H-1B visa sponsored by UTHSCSA. Individuals who hold an employment authorization document Form I-766 (including those in J-2 status but not those granted employment authorization because of asylee/refugee status) must be sponsored for either an ECFMG J-1 visa or H-1B visa as delineated in this policy. They cannot engage in the fellowship training program solely based upon the employment authorization document.

The decision on whether to sponsor a fellow requiring visa sponsorship for an ECFMG J-1 visa or H-1B visa will be left to the discretion of the department providing the training.

Foreign nationals applying for a J-1 exchange visitor visa must be eligible for visa sponsorship under the criteria set forth by the ECFMG. See the [Selected Federal Regulations for J-1 Physicians](#) for a list of key regulations for international medical graduates participating in clinical training programs on J-1 visas.

To be eligible to be sponsored for a H-1B visa, international medical graduates who did not graduate from an accredited medical school in the U.S. must have has passed Parts 1, 2, and 3 of the U.S. Medical Licensing Examination (USMLE) and have a license or other authorization required by
the Texas Medical Board to practice medicine. The applicant must meet all other legal requirements for H-1B status which the Office of International Services (OIS) will determine upon reviewing the applicant’s U.S. immigration documents and other relevant documents.

Administrative and financial costs associated with support of H-1B visa are significant. The decision to financially support an H-1B visa will ultimately rest with the training program and the associated department. University Health System (UHS) will not serve as paymaster (provide salary or benefits) for an individual on an H-1B visa. Thus, the department will be responsible for paying the entire salary and benefits for fellows on H-1B visas in addition to the governmental filing and internal visa processing fees. Moreover, the U.S. Department of Labor determines the required wage for H-1B visas which may be more than the department initially intended to pay.

Understanding the financial obligations and compliance requirements in regards to H-1B visa sponsorship, the program director wanting to sponsor an applicant for a H-1B visa must first contact the OIS and receive their approval prior to the program ranking the applicant on a match list or extending an offer for appointment to the applicant. The program director must await approval of the request before making any commitment to the applicant.

UTHSCSA will not provide sponsorship of permanent residence for international medical graduates in GME training programs under any circumstances.
Mission

The Office of International Services (OIS) supports and enhances the international activities and interests of UT Health San Antonio. OIS serves as the principal administrative office tasked with ensuring compliance with immigration regulations and facilitating the entry/hiring and retention of international students, staff, faculty, trainees and visitors. Advocating on behalf of the international campus population both within the university and to federal and state governmental agencies, OIS ensures that international visitors are afforded the opportunity to complete their educational, research, and/or professional objectives. The OIS also functions as the designated administrative clearing-house and information source for all of the University’s education abroad activities. Lastly, the OIS provides opportunities for intercultural education and exchange, by collaborating with other departments and offices to provide education, social, and cultural programs on campus.

Contact us at 210.567.6241 or international@uthscsa.edu.

Processing Times

The OIS strives to provide excellent customer service, which includes prompt response and processing times. Please refer to the information below outlining OIS estimated response and processing times. OIS kindly asks that immigration processing requests are made with plenty of time to spare, as government processing times are unchangeable and unpredictable.

I-20 Issuance
--5-7 business days
--This includes initial I-20’s, extensions, CPT and OPT, and reduced course load requests.

I-20 Travel Signature
--1-2 business days
--Please drop off the I-20 at the office and we will notify you when it is ready for pick up. If we have evaluated that the request is urgent, we will sign the I-20 the same day for travel.

DS-2019
--5-7 business days
--Please keep in mind that the time it takes to send the DS-2019 overseas, as well as visa wait times and processing times. For estimates, please refer to: http://travel.state.gov/

H-1B Petition
--3-4 weeks
--This is an estimate of how long it takes us to prepare and send the petition to USCIS. Please refer to USCIS for approximate adjudication timeframes: http://www.uscis.gov/

Phone Calls
--Within 24 hours
--If the request is urgent, the Director will be contacted immediately.

Emails
--24 hours; 3-5 business days
--For time-sensitive requests, we will respond within 24 hours; all other non-urgent requests will be responded to within a maximum of 3-5 business days.

Study Abroad Approval
--5-7 business days
--Study abroad packets must be submitted to OIS no later than 30 days prior to trip departure.

Contacts

**Director**
Julie Wilbers
210.567.6222

**Office Manager**
Margaret Yuarte
210.567.6241

**International Services Representative**
Banan Ali
210.567.6238

**International Services Representative**
Patricia Goldspink
210.567.4195

**International Services Representative - Senior**
Laura Paprotta
210.567.6249

Primarily serving 38 counties across South Texas.

Contact Us
www.uthscsa.edu

**Academic Locations**
Joe R. & Teresa Lozano Long Campus
Regional Laredo Campus

**Patient Care Locations**
Center for Oral Health Care & Research
Medical Arts & Research Center
UT Health Cancer Center

**Research Locations**
Greehey Academic & Research Campus
Texas Research Park Campus
ECFMG J-1 Visa Workshop

Presented by the Office of International Services
February 2017

Today's Workshop Agenda

- Definitions
- Overview of Process
- Documents Required
- Compliance
Today's Workshop Agenda - Definitions

ECFMG J-1 Visas – Definitions - ECFMG

- ECFMG is a non-profit organization that:
  1) evaluates the qualifications of international medical graduates and medical schools;
  2) assists International Medical Graduates (IMGs) in process of applying for U.S. GME positions; and
  3) sponsors foreign IMGs for the J-1 visa (Exchange Visitor Sponsorship Program) to participate in GME programs.
The GME Policy Manual states the official policies in regards to all Graduate Medical Education programs at the UT Health Science Center at San Antonio.

The GME Policy Manual can be found on the Office of Graduate Medical Education website.

GME Policy 2.14.a states the policy re: visa sponsorship for Medical Residents. No exceptions to policy.

GME Policy 2.14.b states the policy re: visa sponsorship for Clinical Fellows. No exceptions to policy.

An International Medical Graduate (IMG) is a physician who received his/her basic medical degree or qualification from a medical school located outside the United States and Canada. (U.S. citizens who are IMGs do not require visa sponsorship but do require an ECFMG certificate.)
ECFMG J-1 Visas – Definitions - TPL

- A Training Program Liaison (TPL) is an individual who is designated to serve as the official teaching hospital representative and assists in the communications between the GME training programs, the physician on the ECFMG J-1 visa, and ECFMG to ensure regulatory compliance and provide administrative oversight.

More information and definitions can be found at: www.ecfmg.org/evsp

Today’s Workshop Agenda – Process
Program reviews GME Policy Manual and determines if ECFMG J-1 visa sponsorship is required for medical resident or clinical fellow. Program contacts the Office of International Services (OIS) at 567-6241 or international@uthsca.edu if they have any questions about appropriate visa under GME Policy Manual.

Program submits a complete ECFMG J-1 Exchange Visitors request packet to the OIS. (Forms can be found at www.uthsca.edu/ois). The OIS reviews packet. If documents are missing or additional information is needed, the OIS will contact department.

**OIS Processing Time: 5 to 10 business days**

Once there is a complete ECFMG J-1 Exchange Visitor request packet, the OIS uploads the request packet to ECFMG via their online Exchange Visitor Network (EVNet).

**OIS Processing Time: 1 to 3 business days.**

ECFMG reviews documents uploaded to EVNet and notifies the OIS if additional information or documents are required. ECFMG emails resident or fellow with instructions and any requests to upload required documents to Online Applicant Status and Information System (OASIS).

**ECFMG Processing Time: 4 to 8 weeks**

When ECFMG approves the application, they send the DS-2019 form to the OIS. The OIS will send the DS-2019 form to the resident or fellow. If the physician is abroad, then s/he uses the DS-2019 form to apply for a ECFMG J-1 visa at U.S. consulate.

**OIS Processing Time: 1 to 2 business days.**

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**Today's Workshop Agenda – Documents**

- Definitions
- Overview of ECFMG J-1 Visa Process
- Documents Required
- Compliance
Documents Required

On the OIS website (www.uthscsa.edu/ois/), go to J-1 ECFMG tab and open ECFMG J-1 Exchange Visitor Visa Sponsorship Request Form.

Read and complete the form carefully and select the appropriate ECFMG checklist which details the supporting documents which must be submitted with the completed form to the OIS.

If you have questions about the request form or the checklist, please contact OIS.
Today’s Workshop Agenda – Compliance

Compliance

There are requirements even after the physician receives the ECFMG J-1 visa and checks in with the OIS. The physician, TPLs, and programs all have certain responsibilities.

Failure to meet compliance requirements may result in ECFMG terminating the J-1 record in the federal governmental database SEVIS which would require the physician to immediately depart the U.S.
Compliance – Physician’s Responsibilities

Contact Information

After entering the U.S. on ECFMG J-1 visa, the physician must continually update the following in OASIS:

1) Residential Address
2) Email Address
3) Phone Number

The physician must also notify the USCIS of any address changes online via their website: www.uscis.gov.

The physician should also notify the OIS at international@uthscsa.edu regarding any changes in his/her contact information.

Compliance – Physician’s Responsibilities

Travel Outside of the U.S. – Valid Travel Signature on DS-2019

*Must have signature of ECFMG Regional Advisor in Travel Validation section of DS-2019 form. No-one in the OIS is authorized to sign the form.

*Travel signature is valid for one year from date of signature or until the expiration date of the DS-2019 form, whichever is earlier.

*Physician must upload to OASIS a Request for Duplicate Form DS-2019 to obtain ECFMG signature for Travel Validation. Request form asks for TPL’s or Program Director’s signature, but the OIS requires the Program Director’s signature to confirm that s/he is aware of the physician’s upcoming travel abroad.

*ECFMG requires 7 to 10 business days to issue DS-2019 form with travel validation signature.
Compliance – Physician’s Responsibilities

Medical Insurance

U.S. Department of State regulations require that all J-1 Exchange Visitors including ECFMG J-1 physicians maintain medical, evacuation, and repatriation of remains insurance with certain coverage for the entire duration of their stay in the U.S.

J-2 dependents must also have insurance meeting these requirements for their entire stay in the U.S.

It is the J-1 physicians’ responsibility to ensure that their medical insurance plans meet the regulatory insurance requirements and that J-2 dependents also have the required insurance coverage.

ECFMG provides the required evacuation and repatriation of remains insurance to ECFMG J-1 physicians and their J-2 dependents.

Additional information on the ECFMG website.

Compliance – Program’s Responsibilities

- Delays in Arrival More Than 30 Days
- Elective Rotations
- Proposed Changes to Approved Training Program
- No Moonlighting
- Legal Concerns
Delays in Arrival

If physician is delayed for any reason including visa issuance more than 30 days from the start date of his/her program (as indicated as on the DS-2019 form), then the program must notify the OIS. The OIS will notify ECFMG and they will subsequently advise us of the next steps.
Compliance – Program’s Responsibilities

Proposed Changes to Approved Training Plan
Leaves of Absence

ECFMG must approve in advance whether it be medical, FMLA, educational, or any other leave of absence.

ECFMG wants to know if the HSC continues to have responsibility for the physician as member of training program during leave of absence.

Program must notify the OIS in advance of proposed leave of absence. Include details such as type of leave, dates of proposed leave, continued receipt of benefits, salary, etc…, institutional oversight and/or contact, location of leave (U.S. or abroad), and non-clinical assignments/credits.

Compliance – Program’s Responsibilities

Proposed Changes to Approved Training Plan
Remedial Training

Regulations only allow for maximum of 12 months of repeat training if requested by the Program Director.

ECFMG wants to know if the request is consistent with GME requirements for academic progression.

ECFMG takes into consideration the rationale for the remedial training, credits/rotations, plan of remedial training, presence of periodic evaluations, amended contract, etc…
Compliance – Program’s Responsibilities

Proposed Changes to Approved Training Plan
Resignation or Termination

Program must inform the OIS of official date of release of upcoming resignation or termination so that the OIS can notify ECFMG.

Grievance process and timeline must have been followed consistent with GME Policy.

ECFMG wants to know that the HSC has thought about the potential issues for the program and the physician in the future.

Compliance – Program’s Responsibilities

Proposed Changes to Approved Training Plan
Gaps in Training

For physicians continuing on with GME, there ideally should be no gaps between contracts.

Programs should advise the OIS if there will be a gap in training program for physician and if so, detail if result of off-cycle training, reason for off-cycle (i.e. visa or licensure delays), location during gap (U.S. or abroad), institutional oversight during gap, etc...

If minimal gap, ECFMG will consider options to continue sponsorship and meet regulatory requirements.
Compliance – Program’s Responsibilities

Legal Concerns

Program must notify the OIS immediately if they know that the resident has encountered legal concerns such as arrest, criminal charges, etc… so that the OIS can work with the Office of Legal Affairs, Office of GME, ECFMG, the program and the physician.

Compliance – Program’s Responsibilities

Moonlighting Prohibited

Physicians on ECFMG J-1 visas are only authorized to participate in official program training activities.

If a physician on an ECFMG J-1 visa engages in unauthorized employment including internal moonlighting, ECFMG may have to terminate the physician’s visa status.

For ACGME programs, the training activities are well-defined. For non-standard programs, ECFMG will review the original program description submitted in support of the visa application. Programs may contact the OIS to determine if proposed activities are allowable.
Elective Rotations

Physicians who want to participate in an rotation that is not at an approved ACGME “major participating site” must first receive approval from ECFMG.

ECFMG form requesting approval of off-site rotation requires the signatures of both the Program Director and the TPL.

ECFMG requires submission of the approval request via OASIS or EVNet 30 days in advance.

Compliance – TPL’s Responsibilities

The Training Program Liaisons in the OIS serve to communicate between the program and ECFMG.

The OIS TPLs rely on the Program Coordinators, the Program Directors, and the medical residents or clinical fellows being sponsored to advise us of the mandatory compliance reporting items.

TPLs also participate in ECFMG webinars and outreach programs to stay informed of our institution’s obligations and ECFMG processes.
Team Work & Communication Leads to Success for Everyone

ECFMG

Medical Resident or Clinical Fellow

Training Program

Training Program Liaison (OIS)

OFFICE OF INTERNATIONAL SERVICES

UT Health Science Center

SAN ANTONIO

(210) 567-6241

international@uthscsa.edu

Director: Julie Wilbers
Advisors: Patricia Goldspink
          Laura Paprotta

Office Manager: Margaret Ytuarte
H-1B Visa Process Chart

Department gathers & submits a complete H-1B packet to the Office of International Services (OIS). (Forms can be found at www.uthscsa.edu/ois)

OIS reviews packet. If documents are missing or additional information is needed OIS will contact department.
OIS Processing time: 5 to 10 business days

Once there is a complete H-1B packet, a Prevailing Wage request is submitted to the Department of Labor (DOL).
DOL Processing time: 8 to 10 weeks.

When the prevailing wage is received, a Labor Condition application is submitted to the DOL.
DOL Processing time: 7 to 10 days.

When the LCA is certified, OIS prepares and submits the H-1B request to the U.S. Citizenship and Immigration Service (USCIS).
USCIS Processing time: 6 to 8 months for regular processing or 15 days for premium processing.

* All H-1B fees must be paid by the sponsoring department.
Inter-Departmental Transfer Voucher (IDT) to OIS: $750
Government filing fee to USCIS: $325
Government fraud detection fee to USCIS: $500 (Only required for new H-1B employees to the UT Health Science Center)
Government premium processing fee: $1225 (Additional fee only required for premium processing cases)

Version 1/14/2016
ERAS and the Match
ERAS 2018 Participating Specialties & Programs

ERAS provides comprehensive listings of the specialties currently participating in ERAS. You may view the list of programs in a specific specialty by clicking the specialty name.

**MD Fellowship - July Cycle**

*Adolescent Medicine (Pediatrics)*
*Allergy and Immunology*
*Cardiovascular Disease (Internal Medicine)*
*Child Abuse Pediatrics (Pediatrics)*
*Child and Adolescent Psychiatry (Psychiatry)*
*Clinical Informatics (Anesthesiology)*
*Clinical Informatics (Emergency Medicine)*
*Clinical Informatics (Family Medicine)*
*Clinical Informatics (Internal Medicine)*
*Clinical Informatics (Pathology)*
*Clinical Informatics (Pediatrics)*
*Colon and Rectal Surgery*
*Critical Care Medicine (Internal Medicine)*
*Developmental- Behavioral Pediatrics (Pediatrics)*
*Endocrinology, Diabetes, and Metabolism (Internal Medicine)*
*Gastroenterology (Internal Medicine)*
*Geriatric Medicine (Family Practice)*
*Geriatric Medicine (Internal Medicine)*
*Headache Medicine*
*Hematology (Internal Medicine)*
*Hematology and Oncology (Internal Medicine)*
*Hospice and Palliative Medicine*

**46 specialties, 7 new for ERAS 2018**

*Infectious Disease (Internal Medicine)*
*Medical Genetics*
*Neonatal-Perinatal Medicine (Pediatrics)*
*Nephrology (Internal Medicine)*
*Oncology (Internal Medicine)*
*Pediatric Critical Care Medicine (Pediatrics)*
*Pediatric Emergency Medicine (Emergency Medicine)*
*Pediatric Emergency Medicine (Pediatrics)*
*Pediatric Endocrinology (Pediatrics)*
*Pediatric Gastroenterology (Pediatrics)*
*Pediatric Infectious Diseases (Pediatrics)*
*Pediatric Nephrology (Pediatrics)*
*Pediatric Pulmonology (Pediatrics)*
*Pediatric Rehabilitation Medicine (Physical Medicine and Rehabilitation)*
*Pediatric Rheumatology (Pediatrics)*
*Pulmonary Disease (Internal Medicine)*
*Pulmonary Disease and Critical Care Medicine (Internal Medicine)*
*Rheumatology (Internal Medicine)*
*Sleep Medicine*
*Sports Medicine (Emergency Medicine)*
*Sports Medicine (Family Medicine)*
*Sports Medicine (Pediatrics)*
*Sports Medicine (Physical Medicine and Rehabilitation)*

**DO Fellowship - July Cycle**

*Addiction Medicine*
*Adult and Pediatric Allergy and Immunology*
*Cardiac Electrophysiology*

**21 specialties, 0 new for ERAS 2018**

*Interventional Cardiology*
*Nephrology*
*Oncology*
Cardiology
Critical Care-Medicine
Endocrinology
Gastroenterology
Geriatric Medicine-IM
Hematology & Oncology
Hospice and Palliative Care
Infectious Diseases

DO Residency - July Cycle
Anesthesiology
+Dermatology
Diagnostic Radiology
Emergency Medicine
Family Medicine
Family Medicine/Emergency Med
General Surgery
Integrated FM/NMM
Integrated IM/NMM
Internal Medicine
Internal Medicine/ Emergency Medicine
Internal Medicine/ Pediatrics
Neurological Surgery

26 specialties, 0 new for ERAS 2018
Neurology
Neuromuscular Medicine and OMT
Obstetrics and Gynecology
Ophthalmology
Orthopedic Surgery
Otolaryngology & Facial Plastic Surgery
Pediatrics
Physical Medicine and Rehabilitation
Proctology
Psychiatry
+Public Health and Preventive Medicine
Traditional
Urological Surgery

MD Residency - September Cycle
*Anesthesiology
*Child Neurology (Neurology)
*Dermatology
*Diagnostic Radiology/Nuclear Medicine
*Emergency Medicine
*Emergency Medicine/Family Medicine
*Family Medicine
*Family Medicine/Osteopathic Neuromusculoskeletal Medicine New Specialty!
*Family Medicine/Preventive Medicine
*Family Medicine/Immunology
*Internal Medicine
*Internal Medicine/Anesthesiology
*Internal Medicine/Dermatology

50 specialties, 2 new for ERAS 2018
*Orthopaedic Surgery
*Osteopathic Neuromusculoskeletal Medicine New Specialty!
*Otolaryngology
*Pathology-Anatomic and Clinical
*Pediatrics
*Pediatrics/Anesthesiology
*Pediatrics/Dermatology
*Pediatrics/Emergency Medicine
*Pediatrics/Medical Genetics
*Pediatrics/Physical Medicine and Rehabilitation
*Pediatrics/Psychiatry/Child and Adolescent Psychiatry
*Physical Medicine and Rehabilitation
MD Fellowship - December Cycle

Advanced Heart Failure and Transplant Cardiology  
* New Specialty!

Clinical Cardiac Electrophysiology  *New Specialty!

*Complex General Surgical Oncology (General Surgery)

*Female Pelvic Medicine and Reconstructive Surgery (OB/GYN)

*Female Pelvic Medicine and Reconstructive Surgery (Urology)

*Gynecologic Oncology (Obstetrics and Gynecology)  *New Specialty!

Interventional Cardiology (Internal Medicine)

*Maternal-Fetal Medicine  *New Specialty!

*Pain Medicine (Multidisciplinary)

*Plastic Surgery

*Plastic Surgery-Integrated

*Preventive Medicine

*Psychiatry

*Psychiatry/Family Practice

*Psychiatry/Neurology

*Radiation Oncology

*Radiology-Diagnostic

*Surgery-General

*Thoracic Surgery-Integrated

*Transitional Year

Urology

*Vascular Surgery-Integrated

**MD Fellowship - December Cycle**

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<th>Specialty</th>
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<td>Advanced Heart Failure and Transplant Cardiology</td>
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<td>Clinical Cardiac Electrophysiology</td>
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<td>*Complex General Surgical Oncology (General Surgery)</td>
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</tr>
<tr>
<td>*Gynecologic Oncology (Obstetrics and Gynecology)</td>
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<tr>
<td>Interventional Cardiology (Internal Medicine)</td>
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<tr>
<td>*Maternal-Fetal Medicine</td>
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<tr>
<td>*Pain Medicine (Multidisciplinary)</td>
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</table>

**18 specialties, 5 new for ERAS 2018**

*Pediatric Anesthesiology (Anesthesiology)

*Pediatric Cardiology (Pediatrics)

*Pediatric Hematology/Oncology (Pediatrics)

*Pediatric Surgery (General Surgery)

*Reproductive Endocrinology and Infertility  *New Specialty!

*Thoracic Surgery

*Vascular Neurology (Neurology)

*Vascular Surgery (General Surgery)

*Vascular and Interventional Radiology (Radiology-Diagnostic)

**Indicates specialties that participate with the National Resident Matching Program (NRMP)**

**+** Represents specialties that offer OGME-2 training

**New Specialty!** New for the current ERAS Season
## Participation in Match

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Updated 4/28/2016
The Match® Terms and Topics

AAMC
Association of American Medical Colleges. AAMC represents allopathic medical schools located in the U.S.

AAMC ID
The AAMC ID is a unique identification number assigned by the Association of American Medical Colleges (AAMC) to students, residents, and others who register with a service it sponsors. If not beforehand, Match applicants will receive an AAMC ID number when they register with ERAS®, the Electronic Residency Application Service sponsored by the AAMC. The AAMC ID is a required field for applicants during registration for the Main Residency Match.

ACGME
Accreditation Council for Graduate Medical Education. The ACGME accredits residency and fellowship programs in the United States to ensure training programs meet specialty-specific quality standards.

All In Policy
Any program that registers for the Main Residency Match must attempt to fill all of its positions through the Match or another national matching plan. Fellowship programs in the NRMP Specialties Matching Service® may voluntarily implement the All In Policy.

AOA
American Osteopathic Association. The AOA supports training programs dedicated to teaching the principles of osteopathic medicine and is the accreditation authority for osteopathic postdoctoral training programs until June 30, 2020. The AOA Commission on Osteopathic College Accreditation is given authority by the U.S. Department of Education to accredit colleges of osteopathic medicine.

AACOM
American Association of Colleges of Osteopathic Medicine. AACOM represents osteopathic medical schools located in the U.S.

Applicant Status
The terminology displayed in the NRMP Registration, Ranking, and Results (R3) system to identify an applicant’s status for any Match:

- **Initial**: The applicant has started the registration process.
- **Active**: The applicant has completed the registration process.
- **Ranking**: The applicant has started entering a rank order list but has not certified it for use in a Match.
- **Certified**: The applicant has finalized a rank order list and it is ready to be used when the matching algorithm is processed.
- **Withdrawn**: The applicant has been withdrawn from the Match. U.S. allopathic medical school seniors cannot withdraw themselves from the Match. The NRMP can withdraw applicants from a Match for non-payment or other reasons.
Applicant Type
The classification system used by NRMP to designate applicants participating in Matches:

- **Senior of U.S. Allopathic Medical School (U.S. Senior):** A fourth-year medical student in a U.S. allopathic school of medicine accredited by the Liaison Committee on Medical Education (LCME) who has a graduation date before July 1 in the year of the Match. U.S. seniors are sponsored by their medical schools and may be referred to as Sponsored Applicants.
- **Graduate of U.S. Allopathic Medical School (U.S. Grad):** A graduate of a U.S. allopathic school of medicine accredited by the LCME who has a graduation date before July 1 in the year before the Match. Previous U.S. graduates are not sponsored by the medical school.
- **Student/Graduate of Canadian Medical School:** A student or graduate of a Canadian school of medicine accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS).
- **Student/Graduate of Osteopathic Medical School (DO):** A student or graduate of a medical school accredited by the AOA Commission on Osteopathic College Accreditation (COCA).
- **Graduate of Fifth Pathway Program:** A graduate of a U.S. Fifth Pathway program. The Fifth Pathway Program ceased issuing certificates in 2009.
- **U.S. Citizen Student/Graduate of International Medical School (U.S. IMG):** A U.S. citizen who attends or graduated from an international medical school.
- **Non-U.S. Citizen Student/Graduate of International Medical School (Non-U.S. IMG):** A non-U.S. citizen who attends or graduated from an international medical school.

*Independent Applicants include all applicant categories EXCEPT U.S. allopathic seniors.*

**COMLEX-USA**
Comprehensive Osteopathic Medical Licensing Examination. The [COMLEX](#), administered by the National Board of Osteopathic Medical Examiners, is a three-step examination that assesses medical knowledge and clinical skills and serves as the osteopathic physician's primary pathway to licensure. Students in U.S. osteopathic medical schools typically take the Level 1 examination at the end of their second year. The Level 2-Cognitive Evaluation examination and the Level 2-Performance Evaluation Examination must be taken and passed before graduation. The Level 3 examination typically is taken during or after the first year of residency training.

**Couple**
Any two applicants who link their rank order lists in an NRMP Match. Applicants who participate in the same Match as a couple form pairs of choices on their primary rank order lists, which are considered in rank order when the matching algorithm is processed. A couple matches to the most preferred pair of programs where each partner has been offered a position.

**Couple Status**
The status in the R3 system that lets an applicant know whether couple registration for a Match is complete.

- **Couple Status reads “Pending”** for the partner who initiates a Couple Request in the R3 system.
- **Couple status reads “Request Received”** for the other partner after a notification to confirm the Couple Request is received.
- **Couple Status reads “Accepted”** for BOTH partners when the Couple Request has been confirmed.
Electing to uncouple later in the process will remove the Couple Status from the applicants’ account in the R3 system. *Couple fees are non-refundable, even if applicants later decide to uncouple.*

ECFMG
Educational Commission for Foreign Medical Graduates. ECFMG assesses the readiness of international medical school students and graduates (IMGs) to enter graduate medical education in the United States. To be eligible to train in an ACGME-accredited program, IMGs must obtain ECFMG certification, pass Step 3 of the USMLE, or secure an unrestricted state medical license.

ERAS
Electronic Residency Application Service. ERAS, administered by the AAMC, is a centralized application service that transmits applications and supporting documentation to ERAS-participating residency and fellowship training programs selected by applicants. *ERAS and NRMP are separate organizations with separate registration processes.*

IMG
International medical graduate. An applicant who attends or graduated from a medical school located outside the United States and Canada.

Joint A/P
A feature in the NRMP’s R3 system that allows Match-participating institutions and programs to link an advanced (“A”) PGY-2 program with a preliminary (“P”) PGY-1 program to create a full course of training for applicants interested in specialties that begin in the PGY-2 year. “Joining” an advanced program to a preliminary program - Joint A/P - ensures only applicants who match to the advanced program can match to that preliminary program.

Main Residency Match®
The Match sponsored by the NRMP that places students and graduates of U.S. and international medical schools into ACGME-accredited core residency training programs in the United States.

Match Participation Agreement (MPA)
The contract all Match participants electronically sign as part of the online Match registration process. It outlines the *policies and procedures* for participating in a Match and the steps all Match participants must take to engage in ethical and professionally responsible behavior. *Participants are urged to read the document thoroughly because it becomes a binding contract to honor the results of the Match once participants click the “I Accept” button in the R3 system and the Match registration process is completed.* Match registration *CANNOT* be completed without accepting the terms and conditions of the MPA.
Matching Algorithm
The proprietary mathematical formula used by the NRMP to place applicants into residency and fellowship training programs. The NRMP matching algorithm is “applicant proposing,” meaning the preferences expressed on the rank order lists submitted by applicants, not programs, initiate placement into training.

NBME
The National Board of Medical Examiners. NBME develops assessment tools used in medical education, licensure, and certification. It co-owns and administers the United States Medical Licensing Examination, or USMLE.

NRMP ID
A unique identifier Match applicants receive as part of their registration for an NRMP Match. The NRMP ID is generated by the R3 system and randomly assigned. Although participants must re-register every time they participate in an NRMP Match, the same NRMP ID will be assigned in subsequent Matches. An NRMP ID number is NOT necessary to register for ERAS, but applicants should return to ERAS and enter their NRMP ID into the Personal Information section of their MyERAS application after Match registration is completed.

Osteopathic Recognition
Osteopathic Recognition is conferred upon ACGME-accredited programs that provide training in Osteopathic Principles and Practices. Programs in the Match that have achieved ACGME Osteopathic Recognition can create an osteopathic-focused program or program track for some or all of their positions.

Participant Types
The classification system that designates individual roles in a Match:

- **Applicant:** A medical student, medical school graduate, or physician-in-training who ranks programs in hopes of matching to a residency or fellowship position.
- **Institutional Official:** The NRMP Institutional Official usually is the ACGME Designated Institutional Official and is responsible for oversight of all Match-related activities for the institution’s programs. Upon Match opening, the institutional official must complete a few steps in the R3 system to activate the institution and all programs that will participate in the Match. Programs must be activated before program directors and coordinators can update program information, change the program’s quota, and enter rank order lists. Additionally, institutional officials must approve all quota changes, reversions, and program withdrawals. View the Match 101 Primer for Institutional Officials
- **Institutional Administrator:** An individual assigned by the institutional official to assist with oversight and management of the institution’s programs in the Match. Institutional administrators can add, monitor, and modify program status and information for the institution.
- **Program Director:** The primary contact for managing Match activities for a designated program. The program director enters quota changes and rank order lists and must certify the program’s rank order list.
- **Program Coordinator:** An individual designated by the program director to assist the program director in managing Match activities. The program coordinator can view, create, and edit rank order lists; however, program coordinators are PROHIBITED from certifying rank order lists or editing a certified list.
• **School Official:** An individual designated by the medical school to manage all Match-related activities for the school and to serve as primary contact to the NRMP on all matters regarding applicants from the school. Through the R3 system, the school official verifies the graduation credentials and SOAP eligibility of all senior students and graduates registered for the Main Residency Match.

• **School Administrator:** An individual designated by the school official to assist with oversight and tasks to manage the Match activities for the school. School administrators can view the school's registered applicants and verify graduation credentials and SOAP eligibility.

**Password**
A unique, 8-character-minimum combination of letters and numbers that Match participants use to access the R3 system. Passwords must contain three of the following: English uppercase letter, English lowercase letter, number, special character. All Match participants enter a username and password on the R3 system login page as part of a two-step verification process. *Match passwords are case-sensitive and should not be shared with anyone.*

**PGY-1 & PGY-2**
Post-graduate year one and post-graduate year two training positions. PGY-1 and PGY-2 positions are offered in the Main Residency Match.

**PRISM®**
NRMP's Program Rating and Interview Scheduling Manager (PRISM®). A free mobile app that allows residency and fellowship applicants to track programs during the interview process and create program ratings that can be used to generate a rank order list.

**Program Code**
The 9-digit coding scheme used by the NRMP to identify programs participating in a Match:

- Digits 1-4: the code specifying the institution
- Digits 5-7: the first three digits of the 10-digit ACGME number specifying the specialty
- Digit 8: the one-letter designation specifying the type of program
- Digit 9: the number specifying the track number (track number will be “0” unless an institution has more than one track in a specialty of the same program type)

**Program Status**
The terminology displayed in the R3 system to identify the stage the program is in for any given Match:

- **Initial:** The program activation process has not been completed by the institutional official.
- **Active:** The program is ready to participate in the Match. The program director should update program profile information and verify the program quota.
- **Ranking:** The program has begun entering a rank order list.
- **Certified:** The program has finalized the rank order list and it is ready to be used when the matching algorithm is processed.
- **Withdrawn:** The program has been withdrawn from the Match.
- **Not Participating:** The program is not participating in the Match.
Program Track
The classification system that allows programs to identify multiple training opportunities. Program tracks are used to distinguish between training locations (rural or specific clinical site), focus (e.g. clinical, research, global health, osteopathic recognition) or other distinguishing features within the same program.

Example: 9999140C0 Utopia Medical Center - Internal Medicine
9999140C1 Utopia Medical Center - Internal Medicine/Research
9999140C2 Utopia Medical Center - Internal Medicine/Rural-Watertown

Program Type
The NRMP classifies programs into six types:

- **Advanced (A) programs**: Programs that begin in the PGY-2 year after a year of prerequisite training.
- **Categorical (C) programs**: Programs that begin in the PGY-1 year and provide the full training required to be eligible for specialty board certification.
- **Fellowship (F) programs**: Programs that begin subsequent to completion of a core residency training program.
- **Primary (M) programs**: Categorical programs in primary care Internal Medicine and primary care Pediatrics that begin in the PGY-1 year and provide the full training required to be eligible for specialty board certification.
- **Preliminary (P) programs**: One-year programs that begin in the PGY-1 year and provide prerequisite training for advanced programs.
- **Physician (R) programs**: Programs that offer PGY-2 positions that begin in the year of the Match and are reserved for physicians who have had prior graduate medical education. Physician (R) programs are not available to senior medical students.

Quota
The number of positions a program wishes to fill through an NRMP Match.

Registration, Ranking, and Results® (R3®) system
The web-based software application through which all NRMP® Matches are managed. The R3 system is used to register for a Match, create rank order lists, and view Match results and reports.

Reversions
The option for institutions to revert, or donate, unfilled positions in one program to another program during the matching process. If a donor program does not fill its quota, a designated number (equal to, or less than, the quota) of its unfilled positions can be added automatically to the quota of a receiver program. The reversion process offers some degree of protection against the possibility that positions at an institution will go unfilled and is available for all Matches. A reversion can be created in the R3 system by the program director, but it must be approved by the Institutional Official.

Rank Order List (ROL)
The list of preferences submitted electronically by applicants and programs via the R3 system that is used by the NRMP® matching algorithm to place applicants into residency and fellowship positions.
Supplemental Offer and Acceptance Program® (SOAP®)
During Match Week for the Main Residency Match, the process through which eligible unmatched applicants apply for and are offered positions by programs that did not fill when the matching algorithm was processed.

Specialties Matching Service® (SMS®)
The collection of Fellowship Matches sponsored by the NRMP that places applicants into subspecialty training programs in the United States. The SMS includes more than 25 Fellowship Matches representing more than 60 subspecialties.

Token
A randomized combination of letters and numbers that NRMP sends to new institutional officials, program directors, and school officials to complete the Match registration process. The token allows new users to access the R3 system, create a profile, and set a username and password.

Username
A unique, 8-character-minimum word that Match participants create as part of the Match registration process. All Match participants enter a username and password on the R3 system login page as part of a two-step verification process. Match usernames case-sensitive and should not be shared with anyone.

USMLE
United States Medical Licensing Examination. The USMLE is a three-step examination designed to assess an individual’s ability to apply knowledge, concepts, and principles to the practice of medicine. Seniors in U.S. allopathic medical schools typically take the Step 1 Basic Sciences examination, the Step 2-Clinical Knowledge examination, and the Step 2-Clinical Skills examination before they graduate. The USMLE Step 3 examination typically is taken during or after the first year of residency training. IMGs must pass Step 1, Step 2 CK, and Step 2 CS of the USMLE to be eligible to participate in the Main Residency Match.

Verification Status
The status in the R3 system that lets applicants know whether their credentials have been verified for Match participation. Medical school officials verify the graduation credentials of students and graduates of U.S. allopathic and osteopathic and Canadian medical schools. ECFMG verifies the credentials of U.S. citizen and non-U.S. citizen students and graduates of international medical schools. Credentials must be verified before the Rank Order List Certification Deadline for the applicant’s rank order list to be used when the matching algorithm is processed and prior to Match Week for the applicant to be eligible for SOAP.

- Status reads “Not Verified” when the medical school official or ECFMG has not yet verified the applicant’s eligibility to enter graduate medical education on July 1 in the year of the Match
- Status reads “Verified” when the medical school official or ECFMG has verified the applicant’s eligibility to enter graduate medical education on July 1 in the year of the Match

Violation
A breach of NRMP policy subject to sanction based on the severity of the infraction.

Waiver
Release of a match commitment granted only by the NRMP to an applicant or program. Applicants and program directors are not authorized to release each other from a binding commitment.
Welcome to the National Resident Matching Program® (NRMP®), also known as The Match®. The NRMP conducts the Main Residency Match®, which encompasses more than 42,000 applicants and 30,000 positions. Under the banner of its Specialties Matching Service® (SMS®), the NRMP also conducts Fellowship Matches for more than 60 subspecialties. All Matches are managed through the NRMP’s secure, online Registration, Ranking, and Results® (R3®) system.

All programs new to The Match are asked to complete the New Program Form and email it to support@nrmp.org. (To fill out the form, first save it to your computer. Best viewed in Google Chrome.) The information provided on the form will allow NRMP to create a record in the R3 system and add your program to the appropriate Match. Additional information about the NRMP and how the matching process works can be found using the links below:

- The Match Process
- The Match Terms and Topics
- Match Participant Roles and Responsibilities
- Program Codes and Types
- Match Fees
- Match Week Supplemental Offer and Acceptance Program® (SOAP®)
- Institutional Official Primer: A Tutorial
This message highlights the importance the NRMP places on the professional behavior of all Match participants because strict adherence to the terms and conditions of the Match Agreement is essential to establishing a fair and transparent process.

During the registration process, Match participants electronically affix their passwords to and agree to comply with the terms and conditions of the applicable Match Participation Agreement ("Match Agreement"). The NRMP maintains the highest professional standards in the conduct of its Matches and in its interactions with all participants. Similarly, the NRMP expects all Match participants to conduct their affairs in an ethical and professionally responsible manner.

DEMONSTRATING PROFESSIONAL BEHAVIOR

Participants must demonstrate professional behavior throughout the application, interview, and matching processes by observing practices that protect the right of applicants and programs to determine their selections in the absence of unwarranted pressure and by respecting the binding nature of a match commitment. Failure to demonstrate professional behavior could result in a Match violation and sanctions. The Policies and Procedures for Waiver Requests and the Policies and Procedures for Reporting, Investigation, and Disposition of Violations of NRMP Agreements are incorporated by reference into the Match Participation Agreement and are available for review.

Resources available in the Registration, Ranking, and Results (R³) system can help guide Match participants through the interviewing and matching processes. The Applicant Match History available throughout the year in the R³ system must be used by program directors and NRMP institutional officials to determine whether an applicant has a binding concurrent-year match commitment to another program has requested a waiver of a match commitment and/or has been involved in an NRMP violation investigation. An institution and Program Violations Report also is available in the R³ system to allow applicants and medical school officials to determine whether an institution or program has been involved in an NRMP violation investigation.

EXAMPLES OF UNPROFESSIONAL BEHAVIOR

Failure to comply with all the terms and conditions of the Agreement, whether intentionally or not, may result in an investigation and the imposition of sanctions. The violations most commonly reported to the NRMP include

1. After a Match, an applicant who obtained a position does not accept that position. The Match Participation Agreement states that the listing of a program on the applicant's certified rank order list and the listing of an applicant on a program’s certified rank order list establishes a binding commitment to accept/offer an appointment if a match occurs and to start training in good faith on the date specified in the appointment contract. The same binding commitment is established when positions are obtained through the Match Week Supplemental Offers and Acceptance Program (SOAP).

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2. A program director asks an applicant about ranking preferences or for information about other programs where the applicant has applied or interviewed. Although applicants may volunteer such information, it is a violation of the Agreement if program staff requests that information.

3. An applicant with a binding commitment applies for, discusses, interviews for, or accepts a concurrent-year position in another program prior to receiving a waiver from the NRMP. Similarly, a program director discusses, interviews for, or offers a position to an applicant prior to receiving a waiver from the NRMP. The Match Participation Agreement prohibits applicants and programs from releasing each other from a match commitment. Once parties have matched or a position has been accepted during SOAP, a waiver of the binding commitment may be obtained only from the NRMP.

4. During the application, interview, and/or matching processes, an applicant fails to provide complete, timely, and accurate information to programs. Similarly, a program fails to provide complete, timely, and accurate information to applicants, including a copy of the contract they will be expected to sign if matched to the program and all pertinent information about institutional policies and eligibility requirements for appointment. Programs must provide all such information prior to the Rank-Order List Certification Deadline.

5. During SOAP, a medical school official contacts a program director at the same or another institution on behalf of one of the school's unmatched applicants. The Match Participation Agreement prohibits applicants and any individual acting on the applicants' behalf from contacting programs about unfilled positions prior to the program contacting the applicant after receiving an ERAS application.

NOTE: The foregoing examples are illustrative only. They are not meant to be an exhaustive list of the types of activities that violate the NRMP's Match Participation Agreement.

PROFESSIONALISM AND COMMUNICATION

Interactions between applicants and program directors during the application, interview, and matching processes are an essential component of professionalism. Section 6.0 of the Match Agreement, Restrictions on Persuasion, permits program directors and applicants to express interest in each other but prohibits the solicitation of statements implying a commitment. However, some applicants may misinterpret statements of encouragement to signify a commitment on the part of the program, and some programs may make misleading statements.

Such statements are not binding, and neither applicants nor program directors should rely on them when creating their rank order lists. Program directors, institutional officials, and medical school officials should avoid making misleading statements and at all times display a professional code of behavior in their interactions with applicants. The NRMP recommends that each program director and applicant read carefully the Match Communication Code of Conduct for information on acceptable methods of interaction during the interview and matching processes.
PURPOSE

The National Resident Matching Program® (NRMP®) seeks to maintain the highest professional standards in the conduct of its Matching Program and expects all applicants and programs to conduct their affairs in a professionally responsible manner. Interactions between applicants and program directors during the interview and matching processes must be guided by the Match Participation Agreement, especially the section entitled Restrictions on Persuasion, which makes it clear that applicants and program directors should be free to make decisions on a uniform schedule and without coercion or undue or unwarranted pressure.

The NRMP and the Council of Medical Specialty Societies Organization of Program Director Associations have partnered to create this Match Communication Code of Conduct, which serves as a guide for all residency program staff involved in the interviewing and matching processes.

CODE

To promote the highest ethical standards during the interview, ranking, and matching processes, program directors participating in a Match shall commit to:

- Respecting an applicant's right to privacy and confidentiality: Program directors and other interviewers may freely express their interest in a candidate, but they shall not ask an applicant to disclose the names, specialties, geographic location, or other identifying information about programs to which the applicant has or may apply.

- Accepting responsibility for the actions of recruitment team members: Program directors shall instruct all interviewers about compliance with Match policies and the need to ensure that all applicant interviews are conducted in an atmosphere that is safe, respectful, and nonjudgmental. Program directors shall assume responsibility for the actions of the entire interview team.

- Refraining from asking illegal or coercive questions: Program directors shall recognize the negative consequences that can result from questions about age, gender, religion, sexual orientation, and family status and shall ensure that communication with applicants remains focused on the applicant's goodness of fit within their programs.

- Declining to require second visits or visiting rotations: Program directors shall respect the logistical and financial burden many applicants face in pursuing multiple interactions with programs and shall not require them or imply that second visits are used in determining applicant placement on a rank order list.

- Discouraging unnecessary post-interview communication: Program directors shall not solicit or require post-interview communication from applicants, nor shall program directors engage in post-interview communication that is disingenuous for the purpose of influencing applicants' ranking preferences.

Honest communication between applicants and program staff is essential to a successful matching process. Programs that fail to adhere to the terms of the Match Participation Agreement will be subjected to a violaton investigation as described in The Policies and Procedures for Reporting, Investigation, and Disposition of Violations of NRMP Agreements, which are incorporated by reference and are an integral part of the Match Participation Agreement. The cooperation of all parties in monitoring the conduct of Matches is essential to maintaining a fair and equitable process.
Under the NRMP All In Policy, any program registering for the Main Residency Match® must register and attempt to fill all positions through the Match or another national matching plan. Programs planning to participate in the Match cannot offer positions outside the Match prior to program director registration and program activation. If a position is offered outside the Match prior to program registration and activation, the program is ineligible to enroll in the Match unless the program has been granted an exception to the All In Policy by the NRMP for the position in question.

**POSITIONS THE ALL IN POLICY APPLIES TO**

The All In Policy applies to positions for which the NRMP offers matching services:

- All PGY-1 positions as well as all PGY-2 positions in specialties accredited to begin at either the PGY-1 or PGY-2 level, regardless of whether the program begins in the PGY-1 or PGY-2 year
- PGY-2 positions that are “reserved” for applicants eligible to begin advanced training in the year of the Main Residency Match
- PGY-3 positions in Child Neurology

**Positions NOT subject to the All In Policy include:**

- PGY-2 or higher positions in specialties accredited to begin only at the PGY-1 level
- PGY-3 or higher positions (excepting Child Neurology) in specialties accredited to begin at either the PGY-1 or PGY-2 level
- Positions in ACGME/AOA® dual-accredited programs that are unfilled at the conclusion of the American Osteopathic Association Match

**EXCEPTIONS TO THE ALL IN POLICY**

Requests for exceptions to the All In Policy must be submitted in writing and if approved apply only to the current Match year.

**CLICK HERE FOR LIST OF POSSIBLE EXCEPTIONS TO ALL IN POLICY**

- **Rural Scholars Programs:** Students graduate medical school in three years and commit during medical school to a primary care program at that school.
- **Family Medicine Accelerated Programs:** Students make an early commitment to Family Medicine and are channeled into that track.
- **Innovative Training Programs:** Students recruited into undergraduate medical education programs that integrate with residency training.
- **Military appointees to civilian programs:** Positions reserved for applicants with a military obligation based on pre-existing arrangements between civilian programs and military branch GME offices.
- **Post-SOAP® positions:** Positions created by programs at the conclusion of the Supplemental Offer and Acceptance Program® for partially-matched applicants who need either a PGY-1 or PGY-2 position to complete a full course of training.
- **Off-cycle appointments:** Positions becoming available after the Match opens in September and for which training will begin prior to February 1 in the year of the Match. If training will begin after January 31, the position must be filled through the Match.

Exceptions are not approved for international medical graduates needing visas or for programs in rural and medically underserved areas. The R3 system is flexible and can accommodate special circumstances, including:

- International medical graduates with funding from their home countries
- Combined clinical-research programs where the first year is not clinical training

Requests for exceptions submitted by Rural Scholars, Family Medicine Accelerated Track, and Innovative Training programs must be submitted using the All In Exceptions Form. All other requests may be submitted by email at policy@nrmp.org or by U.S. mail.
“All-In” Policy
Frequently Asked Questions

1. I am the director of an advanced Neurology program, and one of my applicants has received a waiver of her 2014 binding Match commitment. Can I fill her position outside of The Match?

   If a waiver of a binding commitment has been approved by the NRMP, the program may fill the position outside The Match provided training will begin prior to February 1.

2. I’ve received an application from an individual who has returned from the military and wishes to begin training immediately. Can I offer her a position outside of The Match?

   If the applicant can begin training prior to February 1, the position can be filled outside The Match; however, if training would begin after February 1, the applicant and the position must be in The Match.

3. I have a PGY-1 Internal Medicine resident who wants to transfer to my Anesthesiology program at the end of the academic year. Can I offer him a position outside The Match?

   A resident can transfer to a position outside The Match if the position is one for which the NRMP does not offer Matching services. The applicant could transfer to a PGY-2 position in a categorical Anesthesiology program because the NRMP does not offer Matching services for the second-year of training in categorical programs; however, if the program is advanced and thus begins at the PGY-2 level, the applicant and the position must be in The Match because the NRMP provides Matching services for PGY-2 positions in advanced programs, regardless of whether training would begin in the year of The Match or the year after The Match.

4. My program is dually-accredited. Do I have to place all my positions in The Match?

   Programs accredited by both the ACGME and the AOA will register some positions in the AOA Match and some in the Main Residency Match. If the program reverts to the Main Residency Match any positions not filled in the AOA Match, the program will be subject to the Match Week requirements in Section 7.0 of the Match Participation Agreement for Applicants and Programs.

5. I am interested in pursuing a combined clinical-research program where my first year in the program would be research. Can the program offer me a position outside The Match?

   No. The NRMP’s Registration, Ranking, and Results (R3) system allows program directors to create special tracks that have a non-clinical first year of training, so those positions must be offered through The Match.

6. I am an international graduate who has to obtain a visa in order to begin training. Can I accept a position outside The Match to ensure my visa is processed in a timely manner?

   Data from the Educational Commission for Foreign Medical Graduates show that 90 percent of IMGs on J-1 Visas are able to begin training “on time”. Thus, no exception is warranted.

7. I currently am a PGY-2 Pediatrics resident and am interested in pursuing training in Obstetrics and Gynecology. Can I make a mid-career specialty change outside The Match?

   It depends. A resident can make a mid-career specialty change, but if the change is to a position for which the NRMP provides Matching services, the applicant and the program must use The Match. If, however, the applicant would receive sufficient credit for prior training to enter the new program at a level for which the NRMP does not provide matching services, the position may be offered outside The Match.
Policies and Procedures for Reporting, Investigation, and Disposition of Violations of NRMP Agreements

Purpose

The National Resident Matching Program (NRMP) assumes responsibility for instituting measures to protect the integrity of the matching process by requiring all Match participants to behave ethically and responsibly during the matching process.

Policy

It is the policy of the NRMP to require each Match participant to enter into an NRMP Match Participation Agreement and to investigate reported violations of the Participation Agreements, including but not limited to: failure to provide complete, timely, and accurate information during the application, interview or match process; discrepancies in graduation credentials; attempts to subvert eligibility requirements, the matching process or the Match Week Supplemental Offer and Acceptance Program® (SOAP®); failure to offer or accept appointments as required by the results of a Match outcome; and any other irregular behavior or activity that occurs in connection with registration, the submission or modification of a rank order or SOAP preference list, and/or the participant’s commitment to honor any Match outcome.

A. Reporting Procedures

1. The NRMP takes seriously all reports of alleged violations of the Match Participation Agreements. Applicants, school officials, program directors, institutional officials, or any other person may report suspected violations. Reports of suspected violations may be communicated to NRMP in written or electronic form. The NRMP will initiate an investigation if it receives sufficient, credible information that a violation may have occurred. The person reporting the violation may request that his/her identity remain confidential. In addition, allegations of violations may be reported anonymously, however anonymity may impede the NRMP’s ability to investigate.

2. The NRMP will acknowledge all such written reports in order to make an initial verification of their authenticity within seven days of the receipt of the report.

3. Suspected violations must be sent in writing to:

   National Resident Matching Program
   2121 K Street, N.W.
   Washington, D.C. 20037
   EMAIL: policy@nrmp.org

B. Communications

Except as otherwise expressly provided in this Policy, all communications from the NRMP to a Match participant shall be transmitted electronically to the email address designated by the participant at the time of registration in the Registration, Ranking, and Results® (R3®) system. Each Match participant is responsible for providing the correct email address in the R3 system at the time of registration.
References to communications from the NRMP in this policy, the applicable Match Participation Agreement, the NRMP Waiver Policy, or such other policy as may be implemented by the NRMP from time to time shall mean communication by electronic transmission; provided, however, that the NRMP shall continue to communicate confirmed violations of this Agreement in writing as provided in Section D below.

C. Confirmation and Investigation Procedures

Following the issuance of its acknowledgment letter, the NRMP will contact directly the party or parties (applicant, program director, school official, or institutional official) identified in the report of a suspected violation or any other person with knowledge of the incident. These individuals will be informed of the nature of the reported violation and that it is being investigated by the NRMP. All parties identified in the report as relevant to the alleged violation will be requested to provide the NRMP their version of the incident in writing and, if necessary, their response to the allegation(s) within ten business days from the date of the NRMP's request. With respect to the subject of the reported violation, if there is no response to an inquiry from the NRMP after three attempts at contact have been made, the applicant, program, institution, or school (as the case may be) shall be presumed to have engaged in a wrongful act.

1. All allegations will receive a full examination and evaluation. The NRMP is authorized to contact other individuals/institutions in the course of acquiring information/data about the alleged incident.

2. The NRMP will evaluate and/or further investigate the information it receives and, if appropriate, prepare a Preliminary Report as soon as practicable. The Preliminary Report will document the nature of the allegation and the results of the NRMP's investigation.
   a. If the results of the investigation indicate that a violation has not occurred, the case will be closed and all parties identified in the original report will be notified thereof electronically.
   b. If the results of the investigation indicate that a violation may have occurred, the Preliminary Report will be distributed to the subject of the violation, the individual who reported the violation, and any other parties the NRMP considers relevant to the investigation. The parties will be given ten business days from receipt of the Preliminary Report to review and respond to the Preliminary Report and provide additional information to the NRMP.
   c. After receiving any additional information, a revised report will be prepared for consideration by a Review Panel of the NRMP's Violations Review Committee (VRC).

3. The Review Panel will determine whether a violation has occurred and, if so, the appropriate action for the violation. It will issue a Review Panel Report that reports the decision of the Review Panel.
   a. If the Review Panel determines that no violation has occurred, the Review Panel Report will become the Final Report and it will be issued to all parties listed on the Report.
   b. If the Review Panel determines that a violation has occurred, the Review Panel Report will be sent electronically to the subject of the violation investigation. If the subject of the investigation contests the Review Panel decision, the NRMP shall note in the R3 system that the subject of the investigation has a “pending action”. The designation shall remain in place until the subject of the investigation has waived or exhausted the opportunity to contest the adverse action pursuant to Section F below. If the subject of the investigation does not contest the Review Panel decision in accordance with the procedures specified below, the Review Panel Report will become the Final Report and it will be issued to all parties listed on the Report, as well as to those parties specified in paragraph E below. Unless otherwise determined by the Review Panel, the effective date of the Final Report will be the date that it is finalized for issuance to such parties.
An applicant or program may contest an adverse Review Panel Report in accordance with the procedures set forth in Section F below.

D. Interim Corrective Action

At any time before the Match results are released, the NRMP may withdraw from a Match any applicant or program if the NRMP believes it has credible evidence that they have violated the terms of the applicable Match Participation Agreement. If an applicant or program is withdrawn from a Match, the NRMP shall note in the R3 system that the applicant or program is the subject of a “pending action”. The designation shall remain in place until the applicant or program has waived or exhausted the opportunity to contest the adverse action pursuant to Section F below.

The NRMP’s authority to withdraw an applicant or program from a Match is in addition to its authority to impose sanctions for violations of the applicable Match Participation Agreement. Although applicants or programs withdrawn from a Match still will be afforded an opportunity to contest the adverse action pursuant to Section F below, any decision by the NRMP to withdraw an applicant or program shall remain in place and not be subject to suspension in the event the applicant or program chooses to contest the withdrawal or other action by the NRMP pursuant to Section E below.

E. Consequences If Allegations of a Violation are Confirmed

1. For completed investigations confirming a violation of a Participation Agreement by an individual applicant:

   a. The Final Report will be delivered to the applicant with copies to:

      (1) the applicant’s medical school official, with a request that the report be placed in the applicant’s permanent file
      (2) the Educational Commission for Foreign Medical Graduates if the applicant is a student/graduate of a foreign medical school
      (3) the NRMP institutional official and the director of the program to which the applicant matched or accepted a position during SOAP
      (4) the NRMP institutional official and director of the program to which the applicant has applied or switched (if known)
      (5) the party who originally reported the violation
      (6) the NRMP Executive Committee
      (7) the American Board of Medical Specialties
      (8) the American Osteopathic Association
      (9) the applicant’s residency program director if the violation occurred in a fellowship Match
      (10) the Federation of State Medical Boards if the applicant is to be permanently identified as a Match violator or has been permanently barred from future NRMP Matches
      (11) state medical licensure boards, if requested by the applicant
      (12) any parties whom the NRMP has determined are relevant to its investigation.

   b. In addition, the applicant may be barred from subsequent NRMP Matches and/or identified as a Match violator to participating programs for a period of one to three years or permanently, as determined by the NRMP. Violations committed prior to Match Day may result in the applicant being withdrawn from the Match.

   c. The applicant also may be barred for one year from accepting an offer of a position or a new training year, regardless of the start date, in any program sponsored by a Match-participating institution and/or starting a new position or new training year in any program sponsored by a Match-participating institution if training would commence within one year from the date of
issuance of the Final Report. Further, any applicant who has been denied a waiver of a
binding commitment and who does not accept the matched position may be barred for one
year from accepting an offer of a position or a new training year, regardless of the start date,
in any program sponsored by a Match-participating institution and/or from starting a position
in any program sponsored by a Match-participating institution if training would commence
within one year from the date of the NRMP's decision on the waiver. If any of the programs
sponsored by the institution offers a position to that applicant to commence training during
the one-year period or if the applicant accepts or starts such a position, the NRMP will
initiate an investigation to determine whether the applicant, the program, and/or the
institution has violated the terms of the Participation Agreement.

d. An applicant who violates SOAP communications policies may be barred for one year from
participating in SOAP.

e. The decision conveyed in the Final Report will be displayed in the R3 system Applicant
Match History for one to three years or permanently, as determined by the NRMP. Term
limits of any sanction(s) imposed for the violation will be included to identify the length of
time the action is in effect.

The NRMP has sole discretion to determine which of the sanctions described above shall be
applied in the event an applicant violates this Agreement. Failure to comply with sanctions
levied as a result of a confirmed violation may result in a new investigation and imposition of
new sanctions.

2. For completed investigations confirming a violation of a Participation Agreement by a program:

a. The Final Report will be delivered to the program director with copies to:

(1) the NRMP institutional official for transmittal to the institution's graduate
medical education committee
(2) the chair of the institution's graduate education committee
(3) the Accreditation Council for Graduate Medical Education for distribution to
the respective program's Review Committee (RC) and the Institutional
Review Committee
(4) the respective specialty program director association
(5) the party who originally reported the violation
(6) the NRMP Executive Committee
(7) any parties whom the NRMP has determined are relevant to its investigation

b. In addition, the program may be barred from future NRMP Matches and/or identified as a
Match violator for one to three years or permanently, as determined by the NRMP.
Violations committed prior to Match Day may result in the program being withdrawn from
the Match.

c. All programs at a sponsoring institution, regardless of the program's Match participation
status, are prohibited from offering a position to an applicant who has been barred for one
year from accepting or starting a position or a new training year because a waiver request
has been denied by the NRMP or because of a confirmed violation of the applicable Match
Participation Agreement. If a program offers a position to such applicant, or if an applicant
accepts such a position, and training would commence within one year of the date of the
NRMP's waiver decision or the date of issuance of the Final Report, the NRMP will initiate
an investigation to determine whether the applicant or program has violated the terms of the
of the applicable Match Participation Agreement.
d. The decision conveyed in the Final Report will be displayed in the R3 system Institution and Program Violations Report for one to three years or permanently, as determined by the NRMP. Term limits of any sanction(s) imposed for the violation will be included to identify the length of time the action is in effect.

The NRMP has sole discretion to determine which of the sanctions described above shall be applied in the event a program violates the applicable Agreement. Failure to comply with sanctions levied as a result of a confirmed violation that is final may result in a new investigation and imposition of new sanctions.

3. For completed investigations confirming a violation of a Participation Agreement by a medical school:

a. The Final Report will be delivered to the NRMP medical school official with copies to:

(1) the dean of the medical school
(2) the dean of student affairs of the medical school
(3) the Higher Learning Commission and appropriate Regional Accrediting Body
(4) the party who originally reported the violation
(5) the NRMP Executive Committee
(6) any parties whom the NRMP has determined are relevant to its investigation

b. In addition, the school’s access to the password-protected R3 system may be suspended or terminated, as determined by the NRMP.

The NRMP has sole discretion to determine which of the sanctions described above shall be applied in the event a medical school violates the applicable Agreement. Failure to comply with sanctions levied as a result of a confirmed violation that is final may result in a new investigation and imposition of new sanctions.

4. For completed investigations confirming a violation of a Participation Agreement by an institution:

a. The Final Report will be delivered to the NRMP institutional official with copies to:

(1) the ACGME designated institutional official, if different
(2) the chair of the institution’s graduate medical education committee
(3) the president or chief executive officer of the institution
(4) the Accreditation Council for Graduate Medical Education (ACGME) for distribution to the Institutional Review Committee
(5) the party who originally reported the violation
(6) the NRMP Executive Committee
(7) any parties whom the NRMP has determined are relevant to its investigation

b. An institution that participates in any NRMP Match is prohibited from discussing, interviewing, or offering a position in any of the programs sponsored by the institution, regardless of the program’s Match participation status, to any applicant who is ineligible to accept a position who has matched to a concurrent year position through the Matching Program or who is ineligible because of a denied waiver or a confirmed violation by the applicant. Such prohibition applies to all positions which have a start date within one year after the date of the NRMP’s waiver decision or Final Report confirming a violation by the applicant. If any of the programs sponsored by the institution discusses, interviews for, or offers a position to an applicant who is ineligible to accept a position as the result of a denied waiver or a confirmed violation and training would commence within the one-year period, or if the applicant accepts or starts such a position, the NRMP will initiate an
investigation to determine whether the applicant, the program, or the institution has violated the terms of the Participation Agreement.

c. The decision conveyed in the Final Report will be displayed in the R3 system Institution and Program Violations Report for one to three years or permanently, as determined by the NRMP. Term limits of any sanction(s) imposed for the violation will be included to identify the length of time the action is in effect.

The NRMP has sole discretion to determine which of the sanctions described above shall be applied in the event an institution violates the applicable Agreement. Failure to comply with sanctions levied as a result of a confirmed violation that is final may result in a new investigation and imposition of new sanctions.

F. Contesting a Review Panel Report

Nothing in these Policies and Procedures shall prevent any party to a Match Participation Agreement from seeking arbitration to contest a Review Panel Report under the terms of such Agreement. Any party seeking to contest a Review Panel decision must notify the NRMP in writing of the intent to seek arbitration within 10 business days from that party’s receipt of the Panel’s report and must file a written demand for arbitration with the American Arbitration Association (AAA) within 30 calendar days of receipt of such report. If a party seeks arbitration to contest a Review Panel decision, the penalties imposed in and the distribution of the Review Panel Report will be suspended until the arbitration has concluded. If notice of a party’s intent to seek arbitration is not received by the NRMP within 10 business days from that party’s receipt of the Review Panel Report, or if the party does not file a demand for arbitration, including all paperwork and payment of fees (including the Initial Filing Fee and Case Service Fee) using the Standard Fee Schedule provided by the AAA, within 30 calendar days of receipt of the Review Panel Report, that party is deemed to have waived and is barred from later filing a demand for arbitration or seeking other relief. An application for arbitration must be submitted under the Commercial Rules of the AAA. Filing with the AAA is considered complete only when the demand for arbitration has been submitted to the AAA on the appropriate AAA form together with associated fees and has been time/date stamped by the AAA. The arbitration hearing shall commence within six months of filing the demand for arbitration or at another time agreeable to the NRMP.

All notices, reports, and other communications under these Policies and Procedures shall be in writing and shall be deemed received (a) when delivered personally; (b) when received if deposited in the U.S. Mail, postage prepaid, sent registered or certified mail, return receipt requested; (c) 24 hours after being delivered to a nationally recognized and receipted overnight courier service; (d) 24 hours after being sent by e-mail, unless the sending party is notified that the e-mail address is invalid or that the message was not delivered; or (e) when sent by facsimile, provided the sending party has received confirmation that the facsimile was transmitted successfully, to the NRMP at the address shown in Section A or to any other party at the address on file at the NRMP or designated by written notice to the NRMP.

G. When an Investigation is Deemed Complete:

An investigation shall be deemed complete when:

1. The Review Panel Report has been issued and the time frame for seeking arbitration has expired; or

2. In the event arbitration has been timely pursued, the Arbitrator has issued its award and the Final Report has been issued consistent with the award.

Updated June 2017
Checking the Eligibility of Applicants

Program directors in the eight Fellowship Matches opening this month should be sure to use the Applicant Match History available in the NRMP R3 system before scheduling interviews to determine whether applicants are eligible for appointment or have existing match commitments. The Applicant Match History also indicates whether an applicant has an active sanction or has received a waiver.

Applicant Match History support guide | interview resources
Main Residency Match® Program Checklist

REGISTRATION
Match opens: September 15, 2017 at 12:00 p.m. ET

☐ Register for the Match. NRMP accounts are assigned to the user, not the institution or program. Users must not share their username and password.
  • New Program Director/Coordinator: Create your individual account in the Registration, Ranking, and Results® (R3®) system using the token link sent by email when the Match opens.
  • Returning Program Director/Coordinator: When the Match opens, log in to the R3 system by entering your username and password.

☐ Set a program coordinator. If desired, program directors can add a program coordinator in the R3 system to assist with the matching process. The coordinator must create an individual account. It is a Match violation if the coordinator uses the program director’s log in credentials.

☐ Contact the program’s NRMP institutional official (IO) to activate the program for Match participation. Programs will not be able to update any program or quota information until the program has been activated. During the Match, the IO must approve all quota changes, reversions, and other program changes.

☐ Watch the “Institution and Program Match Process” video and view program resources on www.nrmp.org under “Residency”.

☐ Check the program quota in the R3 system. The quota is the number of residents NRMP will attempt to match to the program for the appointment year. The quota can be updated at any time prior to the Quota Change Deadline.

☐ Update the program’s public contact information. This information is made available in the Match Program Rating and Interview Scheduling Manager, or The Match PRISM®, a free smartphone app that allows applicants to track, organize, and rate programs during their interviews.

☐ Be sure all staff involved in the interview and matching processes understand and adhere to the terms of the Match Participation Agreement.

☐ Consult the Applicant Match History in the R3 system to ensure all applicants who are invited for interviews are eligible for appointment. Programs do not need to verify the eligibility of senior medical students because they have no prior Match history.

☐ Remind all interviewees to register for the NRMP Main Residency Match. During the interview, provide applicants with the NRMP program code so they can rank the program.

☐ Create Joint Advanced/Preliminary arrangements in the R3 system, if necessary. Joint A/P arrangements must be created by 11:59 p.m. ET on January 14, 2018.

☐ Like and follow the NRMP on Facebook, Twitter, or LinkedIn for reminders and updates. Use #Match2018 in social media posts and follow the conversation on Tagboard.
RANKING
Rank order list entry begins: January 15, 2018 at 12:00 p.m. ET

☐ Begin **creating the program rank order list (ROL)** in the R3 system. The ROL is the list of applicants, ranked in order of preference, whom the program has interviewed and wishes to train.

☐ **Finalize the program quota.** If the program will not participate in the Match, it must be withdrawn by the Quota Change Deadline.

Quota Change/Withdrawal Deadline: January 31, 2018 at 11:59 p.m. ET

☐ **Set the program's Match Week Supplemental Offer and Acceptance Program® (SOAP®) participation status.** NRMP encourages programs to participate in SOAP in the event some positions are not filled when the matching algorithm is processed. The SOAP participation status must be verified by the institutional official by the Quota Change Deadline.

SOAP Participation Status Deadline: January 31, 2018, at 11:59 p.m. ET

☐ **Set up reversions in the R3 system,** if necessary. Reversions must be entered and approved by the Rank Order List Certification Deadline.

☐ **Finalize and certify the program rank order list by the Rank Order List Certification Deadline.** To participate in the Match, the rank order list must be certified. Do not wait until the last minute to enter and certify the ROL. Program coordinators are prohibited from certifying rank order lists.

Rank Order List Certification Deadline: February 21, 2018, at 9:00 p.m., ET

☐ **Learn about SOAP** and join the Match Week and SOAP Listserv.

RESULTS
Match Week: March 12-16, 2017

☐ **Learn if the program filled and participate in SOAP, if necessary,** at 11:00 a.m. ET on Monday, March 12.

☐ **Review the program's Match results.** *Confidential Roster of Matched Applicants* report will be available by email and in the R3 system on Thursday, March 15, at 2:00 p.m. ET. The information is confidential and cannot be shared until 1:00 p.m. ET on Friday, March 16.

☐ **Celebrate Match Day!** Match Day is Friday, March 16. Results are available to applicants in the R3 system at 1:00 p.m. ET. Matched applicants can be contacted after that time.

☐ **Print Match reports.** The Match will close in the R3 system on June 30, 2018, at 11:59 p.m. ET, and Match reports will no longer be available.
Post-Match
Security Background and Sanction Checks for Resident Applicants

Policy
It is the policy of the University of Texas Health Science Center to require a Security Background and Sanction Check (SBSC) on applicants for graduate medical education (GME) positions sponsored by the University, in which there is:

- Responsibility for the care, safety or security of humans
- Direct access to, or responsibility for, pharmaceuticals, select agents, or controlled substances
- Access to medical records
- Unsupervised access to the Health Science Center.

For the purposes of this policy, the term 'resident' is used to include fellows, as well as any trainee in any non-ACGME accredited GME program.

Specific required checks include:

- Criminal history record information check
- Sanction check
- Selective service check
- Driver's license check

The security background and sanction checks must be accomplished before a resident enrolls in a training program.

Process: The SBSC is required prior to initial enrollment in a training program, whether full time, part time, or in a visiting capacity. The process must be repeated if a resident transfers from one program to another within the Health Science Center, and/or if a resident is hired into a faculty position.

1. All applicants for GME positions will be required to complete and sign the Authorization for Security Background and Sanction Check Form and undergo a SBSC prior to being offered a position. An applicant who refuses to complete, sign and submit the form will be removed from further consideration for the position.
2. Residents who are to be granted a position – either within the NRMP or other match, or outside the match – must have the offered position explicitly contingent on the completion of the SBSC and must undergo the screening prior to entering the program.

3. When indicated, the Chief of Police or designee will confer with the DIO or designee to make a determination of employability of the candidate. If necessary, the DIO may confer with the Dean, the Executive Vice President for Academic and Health Affairs and/or the President. The DIO will be responsible for communicating with the program regarding the candidate's suitability for residency, with specific attention to the following factors:
   a. Specific duties of the position;
   b. Number of offenses;
   c. Nature of each offense;
   d. Length of time intervening between the offense and the employment decision;
   e. Employment history;
   f. Efforts at rehabilitation; and,
   g. Accuracy of the information that the individual provided on the employment application.

h. Criminal history record information will be regarded as confidential as required by law and will not be made a part of the applicant's file or the resident's training file or communicated to any unauthorized person. (Under Texas Government Code 411.085, the unauthorized release of criminal history record information is a criminal offense and, consequently, the Health Science Center should seek legal advice with respect to any requested release of such information.)

4. Security Background and Sanction Check information obtained by the Health Science Center may be used only for the purpose of evaluating applicants for employment and shall in no way be used to discriminate on the basis of race, color, national origin, religion, sex, handicap, or age.

5. All records associated with the SBSC will be retained in accordance with the UTHSCSA Records Retention Schedule.

6. This policy does not automatically disqualify all individuals with conviction records.

7. Costs associated with the SBSC will be borne by the Department in which the applicants' programs are located.

Timing of Process: Programs may conduct the SBSC as follows:

1. At any time prior to match, or
2. Immediately after match results are announced.

In either case, the authorization forms should be signed at the time the applicants are interviewed.
Link to Authorization form:
(http://uthscsa.edu/gme/documents/Criminal_Bacground_MP101_9-2015.pdf)

Institutions participating in clinical training may have additional screening requirements, which must be completed prior to those rotations.
From: Pederson, Travis  
Sent: Friday, February 12, 2016 9:33 AM  
To: Alcaraz, Ailene; Aleman, Veronica R; Barrera, Jacqueline D; Bauer, Maria V; Blaha, Virginia T; Bloom, Rosanna M; Brannen, Cathleen; Buchanan, Barbara A; Candia, Patricia P; Chipps, Christopher L; Cockrum, Annette; Correa, Janet; Craig, Jessica L; Das, Nitin A; De Los Santos, Pauline; DePriest, Lori; Dukes, Javette N; Freabe, Lissette C; Garcia, Guiomar Liliana; Garcia, Irma P; Garza, Kimberly M; Glade, Mike; Gutierrez, Patricia D; Hansmann, Kristen; Hernandez, Lisa Jane; Herrera, Regina H; Hill, Theresa M; Holmes, Shikera; Hudak, Megan; Islas, Ann; Karp, Becky; Keller, Linda A; Kenney-Perez, Edie Ann; Kleffner, Eileen M; Knudsen, Amy; Madla, Magdalene; Mendoza, Lynn B; Molock, Donna A; Montez, Crystal M; Nakajo, Hoi Lan; Navarro, Stephanie Ballesteros; NsurgResidency; Ortiz-Wong, Rachel; Payne, Elizabeth L; Permann, Amy; Powell, Jennifer; Quiroz, Sandra S; Ramirez, Pauline G; Riddle, Debra Lynn; Rodriguez, Celeste A; Salas, Rosalie R; Santa Maria, Emma; Sayles, Melissa; Schifanella, Debbie A; Schreckenbach, Deborah; Schwartz, Deborah L; Smart, Kit C; Strong, Janis R; Valdez, Stephanie M; Waller, Carla; Wright, Andrea L; Zachary, Yolanda  
Cc: Shomette, Jamie; Cano, Ruben M; Parks, Michael; Bready, Lois L; Guzman, Betty A; Hutcherson, Lisa R; Luber, M Philip; Malone, Wendy M; Mesa, Stephanie; Nolan, Robert J Jr; Pederson, Travis; Peel, Jennifer L; Rodriguez, Gabriela C; Tatko, Veronica; Toohey, John S  
Subject: FW: 2016-2017 Background checks for applicants  
Attachments: Criminal_Background_MP101_.pdf  

All-

Just as a reminder your department will be invoiced by the UT Police department for all of the background request that are submitted to them for processing. Please see the communication below that was sent out in September of last year. The cost for this service is $15 for each background check submitted.

Thanks,

Travis Pederson, M.B.A.  
Manager of Finance and Administration  
Graduate Medical Education  
UTHSC San Antonio  
7703 Floyd Curl Drive MC 7790  
San Antonio, Texas 78229-3900  
pedersonj@uthscsa.edu  
(210) 567-0162 Office  
(210) 567-0153 Fax

From: Pederson, Travis On Behalf Of MedGME  
Sent: Thursday, September 10, 2015 4:44 PM  
To: Alcaraz, Ailene; Aleman, Veronica R; Barrera, Jacqueline D; Bauer, Maria V; Blaha, Virginia T; Bloom, Rosanna M; Brannen, Cathleen; Buchanan, Barbara A; Candia, Patricia P; Chipps, Christopher L; Cockrum, Annette; Das, Nitin A; De
Los Santos, Pauline; DePriest, Lori; Duggan, Arianna; Dukes, Javette N; Foster, Yvette; Freabe, Lissette C; Garcia, Guionnar Liliana; Garza, Kimberly M; Glade, Mike; Gutierrez, Patricia D; Hernandez, Lisa Jane; Herrera, Regina H; Hill, Theresa M; 'Holmes, Shikera'; Hudak, Megan; Islas, Ann; Karp, Becky; Keller, Linda A; Kleffner, Eileen M; Knudsen, Amy; Madia, Magdalene; McClain, Peter; Mendoza, Lynn B; 'Holock, Donna'; Monteiro, Juliana; Montez, Crystal M; 'Neuro Surgery'; Ortiz-Wong, Rachel; Payne, Elizabeth L; Permann, Amy; Petersen, Eric J; Powell, Jennifer; Quiroz, Sandra S; Ramirez, Pauline G; Riddle, Debra Lynn; Rivas, Anabel; Rodriguez, Celeste A; Santa Maria, Emma; Schifanella, Debbie A; Schreckenbach, Deborah; Schwartz, Deborah L; Shomette, Jamie; Smart, Kit C; Strong, Janis R; Valdez, Stephanie M; 'Waller, Carla'; West, Kyle K; Zachary, Yolanda

Cc: Ahmed, S Hinan; Alfonso, John Dennis C; Anderson, Kent Lowell; 'Anderson, Shane'; Arandes, Michelle; Bailey, Brigitte Y; Bailey, Steven R; Basler, Joseph W; Birnbaum, Lee A; Bruder, Jan M; Bryan, Eugenia; Carpenter, Andrea J; Cavazos, Jose E; Cestero, Ramon; Cordes, Jeffrey A; Crawford, George E; Crownover, Richard L; 'Dassori, Albana'; Dassori, Albana M; 'DeLee, Jesse'; Dent, Daniel Lawrence; Dumitruc, Daniel; Dyer, Christopher A; Eckmann, Maxim; Erikson, John M; Fiebelkorn, Kristin; Floyd, John R; Fri-Jones, Melissa Joy; Gomez, Yolanda; Guajardo, Jesus R; 'Harnaoka, Derrick'; Healy, Jennifer; Heim-Hall, Josefine; Holder, Kenneth; Jimenez, David F; Karnad, Anand B; Kellogg, Nancy D; Kinney, Marsha C; Lathrop, Kate J; Levine, Stephanie M; Logue, Alicia; Loper, Jorge E; Lunsford, Tisha; Lynch, Jane L; Matthews, Thomas L; McNeil, Christopher; Meffert, Jeffrey J; Moody, Joe M Jr; Morehead, John M; Morrow, Benjamin; Muck, Andrew; Nadeau, Mark T; Newton, Luke A; O'Donnell, Louise; O'Rorke, Jane; Orsi, Carisse; Palladino, Michael G; Palm, Michael L; Parker, Allan; 'Pedersen, William'; Perry, William B; Policarpio-Nicolas, Maria Luis; Prasad, Anand; Quinn, Robert H; Rajani, Rajiv; Ramsey, Patrick S; Restrepo, Marcos; Sanchez-Reilly, Sandra E; Sarantopoulos, John; Schillerstrom, Jason E; Schmitz, Gillian R; Simpson, Charles Blakeley; Srinivasan, Ramesh; Starling, Garrett D; Staudt, Leslie; Stowers, Ashlie R; Suri, Rajeev; Taylor, Richard P; Toohy, John S; Tysinger, James Walter; Valente, Phillip T; Vasquez, Margarita; Venticinque, Steven; Villarreal, Deborah; Wagner, Brent T; Walter, Elizabeth A; Wang, Howard Tz-Ho; Wathen, Patricia I; 'Wells, Jim'; Willis, Ross; Wilson, Travis; Xenakis, Elys Marie-Jeanne; Bready, Lois L; Guzman, Betty A; Hutcherson, Lisa R; Luber, M Philip; Malone, Wendy M; Mesa, Stephanie; Nolan, Robert J Jr; Pederson, Travis; Peel, Jennifer L; Rodriguez, Gabriela C; Tatko, Veronica

Subject: 2016-2017 Background checks for applicants

All-

Please see the attached Criminal Background Form. The background process should follow the following format:

- All interviewing applicants must complete the form at the time of interview (attached to this email)
- All matched residents will need to have their form forwarded to Ruben Cano for processing
- A spreadsheet of all background checks needs to accompany the form (to include name, date of birth, and program)
- The background checks will be performed and results returned to the department no later than 72 hours after submission
- The department will then be invoiced by the police department for the background checks completed

There will no longer be a need to send these forms to HR. Please see Ruben’s contact information listed below:

Ruben Cano
Police Compliance Coordinator
Office of Compliance and Security Sensitive Inquiries
The University of Texas Health Science Center
At San Antonio Police Department
7703 Floyd Curl Dr.
San Antonio, TX 78229-3900
Tel: (210) 567-0671
Fax: (210) 567-6234
E-Mail: canor@uthscsa.edu

If you have any questions or concerns please feel free to contact Ruben for more information regarding this process.

Thanks,

GME team
Criminal Records Check Information

Disclosures: With few exceptions, you are entitled on your request to be informed about the information UTHSCSA collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have UTHSCSA correct information about you that is held by us and is incorrect, in accordance with the procedures set forth in UTS139. You may be required to correct/contest criminal background records with the source of the record. The information that UTHSCSA collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time. Disclosure of your Social Security Number ("SSN") is required of you in order for UTHSC to conduct a criminal background investigation, as mandated by Texas Government Code, Sections 411.094 and 411.086.

Applicant's Full Name: __________________________________________

Date of birth: __________________________________________________

Social security number: __________________________________________

Driver's license number: ___________________________ State of Issue________

Reason for records check__________________________________________ Dept. ______________________

Other name(s) you may be known as (e.g., maiden name, birth name, etc.): __________________________

I hereby authorize UTHSCSA to obtain and/or its agent to obtain and furnish information to UTHSCSA related to my criminal background. I further authorize UTHSCSA to consider that information when making decisions regarding my application status. I consent to providing my fingerprints (only if required) in connection with the criminal background check. I hereby release UTHSC and all its agents and employees, the law enforcement agency, and all employees of law enforcement agencies furnishing information from all liability resulting from the furnishing of this information to UTHSCSA. I certify that the statements made by me on this form and in connection with my application whether on this form or not, are true, complete and correct to the best of my knowledge and belief and I understand that any misstatement, falsification, or omission of information may void my application. I certify that I will report in writing any charges or conviction, excluding misdemeanor offenses punishable only by fine, occurring after the date of this application to the UTHSCSA Police 210-567-2800.

Date______________________________________________

Signature________________________________________

Protection Courtesy Service

Department of University Police | Mail Code 7953 | 7703 Floyd Curl Drive | San Antonio, Texas 78229-3900
210.567.2791 | Fax 210.615.0589 | www.uthscsa.edu | 08/17
Dear Incoming Resident,

On behalf of UT Health San Antonio, University Health System (UHS), and the South Texas Veterans Health Care System (STVHCS), congratulations on your match into the Residency Training Program. We look forward to having you begin your Graduate Medical Education with us!

As required by the NRMP’s Terms and Conditions of the Match Participation Agreement Among Applicants, the NRMP, and Participating Programs (Section 5.0), we ask that you sign, date, and return a copy of the last page of this letter indicating your commitment to train at UT Health-San Antonio. This letter needs to be returned to the program no later than Date Due.

There are many items to be accomplished between now and your start date - some items we would like to call to your attention:

**Checklist:**

<table>
<thead>
<tr>
<th>You</th>
<th>Your program coordinator: (Insert your name and email address here.)</th>
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<tbody>
<tr>
<td>• Sign and return letter to program</td>
<td>• Link &amp; access information – New Innovations</td>
</tr>
<tr>
<td>• TMB PIT application – asap (before 4/1/17)</td>
<td>• Help with setting up and accessing UT Health San Antonio Email account</td>
</tr>
<tr>
<td>• Onboarding – all parts by 6/1/17</td>
<td>• 6/16/17 in-processing – a.m. or p.m.</td>
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<tr>
<td>• Orientation 6/15/17</td>
<td>• TMB personal ID #</td>
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<td>• UT Badge (bring $10)</td>
<td>• What course(s) required; help with registration</td>
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<td>• In-processing 6/16/17;</td>
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<td>• Sign contract, etc</td>
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<td>• UHS health screening – 210-358-2277</td>
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<td>• screening</td>
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<td>• Life Support course(s)</td>
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<td>• Social Security Number (Visa holders)</td>
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</tbody>
</table>

### 1. Onboarding and In-Processing

**Onboarding** refers to the training and administrative processing required prior to a trainee’s beginning residency or fellowship training. Many different entities require new trainees to complete paperwork and other orientation-type activities to maintain accreditation. The University Health System, the VA, and the GME Office accomplish most of these “onboarding” activities via New Innovations (NI).

**In-processing** refers to the in-person process that requires incoming residents to complete tasks for the University Health System and the VA in person.

a. **Onboarding** via New Innovations will be available on April 1, 2017. The VA portion is
due 5/1/2017. Onboarding activities must be completed by June 1, 2017.

1) All onboarding documents will be available on the New Innovations website. Your program coordinator will provide you with the link and access information prior to April 1, 2017. *(Onboarding documents for the VA must be completed by May 1, 2017).*

2) Completion of the GME portion of onboarding will enable you to obtain a UT Health San Antonio ID badge (there is a refundable $10 cash fee) from UT Police prior to the start of your training. Your program coordinator can assist you in obtaining the UT Health San Antonio badge.

b. **In-person**

1) **Orientation** The UT Health San Antonio, UHS, and STVHCS orientation will be held on Thursday, *June 15, 2017*, in the Holly Auditorium located at UT Health San Antonio, 7703 Floyd Curl Dr., San Antonio, Texas 78229.

2) **In-processing will take place on Friday, June 16, 2017.** On that date you will be scheduled with other residents in your program to in-process - this will be in the morning or afternoon (determined by your program and to be communicated to you by your program coordinator). This will include signing your Graduate Medical Education Agreement (Resident Contract). Please bring the following items:

   (a) Vehicle registration or title, and proof of auto insurance to receive a parking hang tag and gate access card.

   (b) A voided check from your financial institution if direct deposit is desired.

   (c) Employment documentation

2. **Resident Permit** - The Physician-in-Training (PIT) Resident Permit application for the Texas Medical Board (TMB) is available online. The link is located on the TMB web page at [https://applications.tmb.state.tx.us/PI/ident1.aspx](https://applications.tmb.state.tx.us/PI/ident1.aspx). The TMB will accept online applications only (please do not complete a paper version of the application). *Your program coordinator will provide you with the TMB Personal ID # for the online application process.* Although there is not a save feature for the online application, you can print each screen as you answer the questions. **The deadline to apply is April 1, 2017.** You must have at least a temporary permit by July 1, 2017 in order to begin your residency training on time.

3. **Health Screening** - All residents must complete the University Health System’s (UHS) health screening. The University Health System (UHS) Employee Health Clinic (3rd floor) is open Monday through Friday from 7:30 a.m. to 4:00 p.m.

   a. **It is imperative you complete the health screening prior to June 17, 2017. Failure to complete the required health screening will jeopardize the start of your training on July 1st.**

   b. **PPD:**

      (1) If you will be receiving a PPD at the clinic, the PPD must be placed on any weekday other than Thursdays in order to allow for a reading within 48-72 hours of placements. Readings must be done at the University Health System (UHS)
Employee Health Clinic.

(2) If you choose to have your PPD performed elsewhere, the document provided to the UHS clinic must indicate the date placed, date read, and the results, positive or negative.

c. All incoming house staff must report to the Employee Health Clinic in person to obtain a mask fit test and complete their health screening. You must be clean-shaven for the mask fit test (contact UHS Employee Health for information pertaining to hospital policies related to this). We highly encourage you to complete the health screening prior to the June 16th in-processing to avoid delays. Employee Health is open Monday-Friday from 7:30am to 4:00pm and appointments can be made by contacting 210-358-2277 or emailing Yolanda.Castro@uhhsa.com. Employee Health has set the following schedule to complete the 2017 health screening:

(1) Prior to June 1, an appointment is required.
(2) During June, no appointment is necessary; however, incoming house staff will be seen on a first come, first served basis as the clinic’s schedule allows. We encourage you to schedule an appointment if possible to avoid a long wait.
(3) On Tuesday, June 13 and June 20, and on Thursday, June 15 and June 22, the clinic will be closed to employees and will assist incoming house staff only. If a PPD is placed at the clinic, you will not be able to schedule a Thursday appointment as the Employee Health Clinic must be able to read the PPD within 48-72 hours of placement and Saturday/Sunday does not fall within normal clinic hours.
(4) After June 30, an appointment is required.
(5) Employee Health clearance is mandatory to start your training program. Failure to clear Employee Health will result in a late start date.

4. Life Support Training - All programs require at least BLS. Your program may require additional certifications as well (ACLS, ATLS, PALS, etc.) - requirements are different for each residency training program.

a. If you have recently completed the certifications your program requires, please upload a copy of both sides of your card to the on-line orientation module of New Innovations.

b. If you need to schedule a course, you will be required to register. All participants must be registered by your Program Coordinator in order to attend. Once registered, you will receive an email from the Center for Learning Excellence with course details, requirements and location. Due to space limitations, it is highly encouraged that you certify prior to arriving for in-processing. Upon completion of the course(s), please be sure upload a copy of your card (both sides) to the on-line orientation module of New Innovations.

(1) BLS is being offered by University Hospital on Wednesday, June 14, 2017. There will be a morning (8:00am-10:30am) and afternoon (11:00am – 1:30pm) session.

(2) ACLS is also being offered by University Hospital and is scheduled for June 19th and 20th. Both sessions will be all day (8:00am-4:30pm). A pre-test certificate/result with a 70% or higher score is required to be admitted to these courses.
5. **Contact** - It is vital we are able to contact you between now and the time you begin your residency training on July 1, 2017. Please notify your program coordinator of any updates on changes of address, phone numbers, and/or email address in order to maintain this contact. Once you have your new address and phone number in San Antonio, please ensure that this information is forwarded to UHS, STVHCS, and the GME office. Your program coordinator will be able to assist you with this. **Once you have received your UT Health San Antonio email address that will be the preferred email address through which your program and we will communicate with you.**

6. **UT Health San Antonio Email:** You will be assigned a UT Health San Antonio domain and exchange (email) account once you upload a Social Security Card to New Innovations. **Your program coordinator will let you know how to access it and set it up.** This will be your primary email address for communications concerning your residency training. (If you graduated from our School of Medicine, you have a LiveMail account; unfortunately, it does not afford the level of security needed and you will need to use the UT Health San Antonio domain and exchange accounts.)

7. **Contingencies.** Your appointment as a trainee is contingent upon the following conditions:

- Graduation from medical school and obtaining original medical diploma and final transcript
- Securing a Texas Medical Board license or Physician-In-Training permit to practice medicine
- Completion of all onboarding
- Completion of all health screening with satisfactory outcomes
- Satisfactory security background check
- If a graduate of an international medical school, ECFMG certification
- If a noncitizen, appropriate visa or other documentation
- Social security number

Once again, welcome to your residency program at UT HEALTH SAN ANTONIO, UHS and STVHCS. Please feel free to contact us if you have any questions. We look forward to working with you!

Sincerely,


Program Director

Program Coordinator

Lois L. Bready, M.D.
Vice Dean for Graduate Medical Education
August 29, 2017

I, Incoming resident's full name, am committed to beginning residency training in Residency Program, on July 1, 2017, in accordance with the Terms and Conditions of the Match Participation Agreement Among Applicants, the NRMP, and Participating Programs (Section 5.0). I understand that beginning my training is contingent on the following all **no later than 6/30/2017**.

- Graduation from medical school and obtaining original medical diploma and final transcript
- Securing a Texas Medical Board license or Physician In Training permit to practice medicine
- Completion of all onboarding
- Completion of all health screening with satisfactory outcomes
- Satisfactory security background check
- If a graduate of an international medical school, ECFMG certification
- If a noncitizen, appropriate visa or other documentation
- Social security number

______________________________
Signature
**TO: GEORGE HERNANDEZ, PRESIDENT/CEO, UNIVERSITY HEALTH SYSTEM**  **FROM: Dept. of**

**SIGNATURE: _________________________________, Chairman/Program Director**  **Date: _________________________________**

**SUBJECT: **NEW/INCOMING HOUSESTAFF PHYSICIAN GRADUATE TRAINING AGREEMENT(S) CONTRACTS**

<table>
<thead>
<tr>
<th>NAME (Last, First, M.)</th>
<th>DEGREE</th>
<th>SPECIALTY</th>
<th>PGY LEVEL</th>
<th>ANNUAL CONTRACT DATES</th>
<th>FUNDING</th>
<th>FOR UHS USE</th>
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*Do not use this form for residents who are switching from other specialties*
TO: GEORGE HERNANDEZ, PRESIDENT/CEO, UNIVERSITY HEALTH SYSTEM  FROM: Dept. of __________________________
SIGNATURE: ___________________________________, Chairman/Program Director  Date: __________________________

SUBJECT: *SWITCHING SPECIALTIES

<table>
<thead>
<tr>
<th>NAME (Last, First, M,)</th>
<th>DEGREE</th>
<th>CURRENT SPECIALTY</th>
<th>NEW SPECIALTY</th>
<th>EFFECTIVE DATE</th>
<th>FOR UHS USE</th>
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</table>

*This form should be completed by the department/division that the physician will be switching to. Please do not forget to list these physicians on your renewing list.
TO: GEORGE HERNANDEZ, PRESIDENT/CEO, UNIVERSITY HEALTH SYSTEM  FROM: Dept. of ________________________________
SIGNATURE: ___________________________________ Chairman/Program Director  Date: ________________________________

SUBJECT: *SWITCHING FUNDING

<table>
<thead>
<tr>
<th>NAME (Last, First, M,)</th>
<th>DEGREE</th>
<th>CURRENT FUNDING</th>
<th>NEW FUNDING</th>
<th>EFFECTIVE DATE</th>
<th>FOR UHS USE</th>
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*PLEASE LIST THE ABOVE PHYSICIANS ON YOUR RENEWING CONTRACT REQUEST FORM.
Onboarding
PD PLUS (Program Leadership Update Series)

March 2017

Resident/Fellow Onboarding

Why is this topic important?

Onboarding refers to the training and administrative processing required prior to a trainee’s beginning residency or fellowship training. Many different entities require new trainees to complete paperwork and other orientation-type activities to maintain accreditation. The University Health System, the VA, and the GME Office accomplish most of these “onboarding” activities via New Innovations (NI). The remainder of this PD Plus will describe in detail the 2017 Onboarding Process. Henceforth, the term “resident” refers to both residents and fellows.

It is important to remember that although onboarding is aimed primarily at trainees that are new to the institution, trainees switching programs (for instance, Internal Medicine to Rheumatology) will also be expected to “onboard,” but with a shorter list of “to-dos.”

Timeline for Onboarding:

Match Day for the Main Match in NRMP is March 17, 2017. After Match, Program Coordinators and incoming residents and fellows should take the following steps:

1. Program Coordinators:
   a. After Match Day, coordinators should change statuses of residents who matched with their program to “Will Start” in ERAS, and inform Wendy Malone when all applicable residents are marked accordingly. If a program does not use ERAS, the coordinator should send the “Alphabetical Listing of Incoming Physicians” form (Alpha Form) they send Marilyn to Wendy so that new trainees’ basic information can be entered manually into Ni.
   b. Coordinators will be able to access new resident and fellow records in NI after March 17th (dependent upon residents’ being marked “Will Start” or Alpha Forms received) in order to obtain NI user names and passwords for each new trainee.
   c. Coordinators should customize the Welcome Letter linked to the end of this document to meet the needs of their program, and email it to their new residents. This letter includes the steps in the orientation process, as well as checklists for both the incoming resident and the Program Coordinator. The letter also contains a commitment page that requires the new trainee’s signature. It is suggested that coordinators include access information for New Innovations in this letter so that their new residents may start working on their checklists as soon as possible. If coordinators choose not to include Ni access information in the Welcome Letter, they will need to disseminate this access information in some other fashion.
   d. Coordinators will be asked to monitor their residents’ progress through the onboarding process. Coordinators are asked to assist residents with general questions and technical issues (such as access to the software and/or problems uploading documents).
2. **Incoming trainees:**
   a. Incoming trainees should sign and return the last page of the Welcome Letter to their Program Coordinator.
   b. They should attend to the checklist items (in the Welcome letter).
   c. They should log in to NI and complete the assigned onboarding items. Trainees are advised to read instructions very carefully and be aware that the onboarding process is time-intensive. Failure to complete items by their due date will jeopardize their start date.

**Content of Resident Onboarding:**

- GME Administrative In-processing (required of all residents)
- GME Training Modules (required of all residents)
- International Medical Graduate Checklist (required of all international medical graduates)
- UHS Checklist
- UHS Employee Health Checklist
- UHS Benefits Checklist
- VA Checklist
- *Pending – OIS Checklist*

In addition, residents switching specialties will have an onboarding checklists. Coordinators who manage the program the resident will begin in 17-18 are responsible for ensuring these checklists are completed before the resident begins the new program.

**What can YOU do to prepare for a successful onboarding experience for your residents?**

- Coordinate with Wendy Malone on which checklists your new residents will receive (for example, Pediatrics and Ob/Gyn residents would not complete the VA Checklist). Coordinate with Wendy if your resident is switching UTHSCSA-sponsored programs as they will be expected to complete an Advancement Checklist. New-to-campus residents will receive onboarding checklists with more items than residents simply switching programs.
- Be aware that residents switching specialties may need to obtain PITs for their new specialty.
- Be aware that residents who have recently obtained a State license have a limited time to obtain a DEA license, as they will no longer be eligible to use the Hospital’s license.
- Ensure residents are aware that onboarding is a time-intensive process and should be started immediately.
- Determine what, if any, additional information your program will gather in the Program-Specific Checklist, and create this Checklist. Webinars on creating checklists are available in Ni.

**Onboarding Items – This is not a comprehensive list of items, but it contains most of the items that will be requested of residents.**

**GME Administrative Processing Checklist**

- House Staff Data Sheet
- Request for Uploaded CV
- Request for Uploaded Medical School Diploma
• Request for Uploaded Social Security Card (back and front)
• SSN Disclosure Form
• Training Permit Application
• Request for Uploaded State License (if applicable)
• Request for Uploaded DEA (if applicable)
• Confidentiality and Security Acknowledgement
• Option to Decline BCMS/TMA Membership
• Medicare Part D Enrollment to Prescribe

GME New Resident Orientation Training Modules Checklist

• IHI Open School – 13 hour module
• Joint Commissions National Patient Safety Goals
• Sleep and Fatigue Modules in the Knowledge Center (KC)
• Infection Control Modules (4) (KC)
• Supervision
• Incident Reporting
• Incident Reporting in MIDAS
• Patient Hand-offs (Series of 4)
• Restraint Training (KC)

University Health System In-processing Checklist

• Welcome Letter
• Graduate Medical Education Application
• Clinical Reference Forms
• Employment Documentation
• National Provider Identifier (NPI) Instructions
• Employee’s Withholding Allowance Certificate (W-4)
• Texas Public Information Act
• Credentialed Provider Access Request Form
• UHS Confidentiality Agreement
• House Staff Manual
• Medical-Dental Staff Bylaws
• Acknowledgment of House Staff Manual & Medical-Dental Staff Bylaws
• Health Information Authorization
• Automatic Deposit of Salary
• Electronic Medical Record Training
• Request for Uploaded BLS Certification
• Request for Uploaded ACLS Certification
• Request for Uploaded Training Certificates
University Health System Employee Health Checklist

- Resident Health Screening Questionnaire
- Mask Fit Form
- Request for Uploaded Documentation of the Following Immunizations:
  - TDAP
  - Varicella
  - MMR
  - Hepatitis B
  - Influenza
  - TB Screening

University Health System Benefits Checklist

- Benefit Enrollment Form
- Dependent Documentation
- Benefit Guide
- HMO Provider Directory
- HMO & PPO Procedure Authorization
- Preferred Drug List
- Summary of Benefit Coverage (SBC)
- Guardian DHMO Fee Schedule
- Guardian Provider Directory
- VALIC Flyer
- VOYA Flyer
- UHS Family Care Plan Medicare Part D Notice
- Health Exchange Notice

VA In-processing Checklist

- VA Welcome letter
- VA Resident Application
- Declaration of Federal Employment
- Appointment Affidavit
- Without Compensation Memo
- Disbursement Agreement
- Mandatory Training Modules
- CPRS Quiz
- Prior VA Experience Verification
- Fingerprint Badge Form
- Fingerprinting/PIV Appointment Process
Courtesy Fingerprint Memo

International Medical Graduate Checklist

- ECFMG Certificate

Program-specific Onboarding

- Anything your program needs that is not addressed in any of the checklists above

Resources:

Welcome Letter Template

Next Month: Wellness
Processing of Incoming Residents/Fellows

Step 1:

The first step is to make sure your incoming residents/fellows get records created in Ni. This process drives all subsequent processes in the UT system mentioned below.

Residents are given records in Ni by either of 2 ways:

A. If you use ERAS and mark the person’s status as “Will Start,” their data can be uploaded through an import the GME Office performs from ERAS.
   a. Be aware that SSN’s are no longer in ERAS, and you will have to ensure that the GME Office enters them into New Innovations.
B. If you don’t use ERAS, or cannot access ERAS for any reason, you can forward a UHS incoming Alpha form listing your trainees’ dates of birth and Social Security Numbers.
BADGE REQUEST FOR MEDICAL RESIDENT

Request for a UTHSCSA Badge for Incoming Residents/Fellows & Visiting Residents

The information below needs to be completed by the program coordinator and then given to the resident/fellow to take to UT Police to obtain their badge. **Cost: $10**

If your resident/fellow will need parking at the MARC or CTRC, please check the appropriate box below so that the badge can be coded to allow gate access for parking or entrance to the MARC building.

Access to:
- [ ] MARC Building
- [ ] CTRC

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Credentials (DO, MD, MBBS, DPM, etc.)</th>
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<tr>
<th>Program Coordinator Name</th>
<th>Program Coordinator Phone</th>
<th>Program Coordinator Email</th>
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<th>Badge Number</th>
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August 7, 2012
GME Orientation
<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Agenda Item</th>
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</thead>
<tbody>
<tr>
<td>7:00 - 8:00 am (Holly Auditorium Foyer)</td>
<td>Registration</td>
<td>Residents check-in / GME / UHS I-9 processing and Breakfast.</td>
</tr>
<tr>
<td>8:00-8:15 am (Holly Auditorium)</td>
<td>Welcome</td>
<td>Robert J. Nolan, Jr., M.D., Associate Dean for Graduate Medical Education &amp; UT Health San Antonio Interim Designated Institutional Official; Professor and Associate Chairman, Department of Pediatrics. Ron Rodriguez, M.D., Interim Dean, UT Long School of Medicine, Professor and Chairman of the Department of Urology. Col. Mark True, M.D., San Antonio Uniformed Services Health Education Consortium. M. Philip Luber, M.D., Associate Dean for Graduate Medical Education; Professor and Vice Chairman, Department of Psychiatry, Chair Department of Medical Education. Jennifer L. Peel, Ph.D., Assistant Dean for Graduate Medical Education, Professor, Anesthesiology. John S. Tooney, M.D., Assistant Dean for Graduate Medical Education, Assoc. Professor, Orthopaedics. Edward Chu, M.D., Resident, Department of Ophthalmology, Housestaff Council President. Kirleen Neely, Ph.D., Behavioral Health Consultant, Faculty Associate. Bonnie Blankmeyer, Ph.D., Professor of Psychiatry, Executive Director, Faculty and Student Ombudsperson and ADA Compliance; and Equal Opportunity/Affirmative Action.</td>
</tr>
<tr>
<td>8:15-10:00 am</td>
<td>UTHSCSA-GME</td>
<td>Robert J. Nolan, Jr., M.D., Associate Dean for Graduate Medical Education &amp; UTHSCSA Interim Designated Institutional Official; Professor and Associate Chairman, Department of Pediatrics.</td>
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<tr>
<td>10:00-10:30 am</td>
<td>Break</td>
<td>Refreshments.</td>
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<tr>
<td>10:30-12:00 pm</td>
<td>UHS</td>
<td>Dr. Alsip, CMO, Leadership Report, UHS. Dr. Purohit, CIO, Sunrise, UHS. Lisa Dodge, Executive Director, Clinical Documentation, UHS. Velma Perales-Diaz, Executive Director, HIM, UHS. Sherry Johnson, Vice President, Integrity/Regulatory Services, UHS. Michelle Ingram, Vice President Quality Report, UHS.</td>
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<td>12:00-12:30 pm</td>
<td>Lunch</td>
<td>Box Lunches provided by UHS.</td>
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<tr>
<td>12:30-1:45 pm</td>
<td>UHS</td>
<td>Leni Kirkman, Sr. Vice President, Social Media, UHS. Jessica Gavia, Director, Patient Relations, UHS. Pamela Mann, Clinical Learning Consultant, UHS. Sherrie King, Deputy Chief, Protective Services, UHS. Danny Taylor, Emergency Preparedness Coordinator, UHS.</td>
</tr>
<tr>
<td>1:45-2:15 pm</td>
<td>Break</td>
<td>Refreshments provided by VA.</td>
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<tr>
<td>2:15-3:15 pm</td>
<td>VA</td>
<td>Julianne Flynn, M.D., Chief of Staff, Audie L. Murphy Veterans Healthcare System. David Dooley, M.D., Associate Chief of Staff, South Texas Veterans Healthcare System. Designated Education Officer; Associate Professor of Medicine, UTHSCSA.</td>
</tr>
</tbody>
</table>

* Attendance of all sessions is required. UHS & VA Hospital In-Processing on 6/16/17 is required for July 1 start date.

**GME Topics:** GME Office, GME Website, ACGME, Duty Hours, Fatigue Mitigation, TMB, HIPAA, Parking, Quality Improvement/Patient Safety, Resident as Teacher

**UHS Topics:** Opening, UHS Leadership, Social Media, Cultural Competence, Medical Records, Quality & Infection Control, Security & badging, Emergency Management, Integrity, Clinical Documentation, Resident Well Being

**VA Topics:** VA policies, program highlights
The University Health System and South Texas Veteran’s Health Care System in-processing will be held on Friday, June 16, 2017. Check-in will be in the Cypress Room located on the first floor of University Hospital by the “D” Elevator. We will be conducting in-processing from 7:30 am – Noon only. To avoid congestion and to have a smooth traffic flow, we will be staggering the times for each department. Please note your time below:

<table>
<thead>
<tr>
<th>Time</th>
<th>Departments</th>
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<tbody>
<tr>
<td>7:30 am</td>
<td>Pediatrics (all), Plastic Surgery, Vascular Surgery, Surgical Critical Care</td>
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<tr>
<td>8:00 am</td>
<td>General Surgery, Otolaryngology, Neurosurgery, Urology</td>
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<tr>
<td>8:30 am</td>
<td>Radiology (all), Pathology (all), Radiation Oncology</td>
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<tr>
<td>9:00 am</td>
<td>Internal Medicine</td>
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<td>9:30 am</td>
<td>Anesthesiology (all), Orthopaedics, Podiatry</td>
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<td>10:00 am</td>
<td>Family Medicine, Rehab Medicine</td>
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<tr>
<td>10:30 am</td>
<td>Ob/Gyn (all), Oral Surgery, Ophthalmology, Thoracic Surgery, Emergency Medicine</td>
</tr>
<tr>
<td>11:00 am</td>
<td>Psychiatry (all), Neurology (all)</td>
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<tr>
<td>11:30 am</td>
<td>Medicine Residencies/Fellowships (other than Internal Medicine)</td>
</tr>
</tbody>
</table>

Residents must bring the following documentation to in-processing:

- one document from List A or one document from List B and one document from List C for the I-9 Employment Eligibility form (posted on New Innovations checklist). A military ID is List B document and must be accompanied with a List C document. Non-US citizens will be required to bring their foreign passport, visa w/I-94, and DS-2019, or Permanent Resident Card. EAD Cards will only be accepted with UTHSCSA OIS approval.
- Any BLS/ACLS cards not already uploaded to New Innovations.
- If direct deposit is desired, a direct deposit form and voided check from the resident’s financial institution must be provided.
- vehicle registration or title and proof of insurance is required to receive parking privileges.
- Any benefits documents not already provided to Human Resources.

BLS courses are scheduled for June 14, 2017, from 8:00 a.m. to 10:30 a.m., or 11:00 a.m. to 1:30 p.m. The ACLS 2-day course is scheduled June 19-20, 2017 from 8:00 a.m. to 4:30 p.m. The PALS 2-day course is scheduled June 26-27, 2017 from 8:00 a.m. to 4:30 p.m. All courses will be held at the Highpoint Towers located at 8415 Datapoint Drive. Registration for the BLS, ACLS, and PALS courses will be done by Marilyn Dahl in Professional Staff Services. Please email your requests to
Marilyn.dahl@uhss-sa.com. You must have a name to go with the requested slot. Registrants for the BLS course must obtain a keycode from the UHS cashier’s office ($22), take the Part 1 online portion and bring the completion certificate with them to the class. Registrants for the ACLS and PALS course must pass a pre-test with 70% score to be admitted to the course (link and code for pretest is in the manual). Participants must bring the pretest certificate/result and ACLS/PALS provider manual on the day of the class. Due to space limitations, we encourage incoming house staff to certify prior to arriving for in-processing.

In addition to onboarding requirements, all residents will be required to have a Texas Physician in Training permit or Texas Medical License, a minimum of BLS certification, and clearance from the Employee Health Clinic to begin training on July 1.

The Sunrise EMR course is required to be scheduled before July 1, 2017. To schedule your incoming housestaff, please email computer.training@uhss-sa.com. Onboarding now requires a pre-test to be completed before attending this course. A link to the course will be emailed to the new house staff (preferably their UTHSCSA email account).

All residents are encouraged to complete a health screening at the University Hospital Employee Health Clinic located on the 3rd floor UH prior to in-processing on June 16, 2017. Residents should have already uploaded the required Employee Health documents to New Innovations. Any incomplete requirements will have to be completed at their Employee Health visit. All incoming house staff must complete an Employee Health Screening and be mask fit tested before starting. The mask fit test requires them to be clean-shaven unless they provide a letter from their physician or religious leader stating why they cannot shave.

The Employee Health Clinic is open Monday through Friday from 7:30 a.m. to 4:00 p.m. House Staff can access the appointment requirements on the Welcome Letter posted to the UHS GME Checklist in New Innovations On-boarding. Contact for appointments are (210) 358-2277 or employee.health@uhss-sa.com. An incoming alpha form with their information must have been received by Professional Staff Services before employee health can set up an appointment.

UHS and STVHCS will not in-process residents unless all on-boarding has been completed, the above in-processing requirements have been met, and the orientation on Thursday, June 15, has been attended or excused by the GME office. If you have late-start residents/fellows, please contact Professional Staff Services to set up a convenient time for in-processing.

Please feel free to contact us at the Professional Staff Services office, UH ext. 8-0163/8-0062 if you have any questions.
Malpractice
Requests for a Claims History aka Loss Run Report/Verification of Coverage: A brief memo stating "I authorize the University of Texas System to release my medical liability claims history" must be included with your request. The document must include your signature - UTS policy does not accept electronic signatures. Scan/email request to HealthLawCredentialing@utsystem.edu or fax to (512) 499-4523.

Certificate of Liability/Facesheet: Contact the Department/Specialty you are associated with to get a copy

Type of Coverage - Occurrence or Tail Coverage: Coverage is per Occurrence and individual and therefore tail coverage is not required, not shared and follows official assignments, i.e. residency rotations in the following amounts:

Staff Physician: $500,000 per claim / $1,500,000 annual aggregate
Resident: $100,000 per claim / $300,000 annual aggregate

Nurse Practitioners (NPR) and Physicians Assistants (PA) are indemnified under Chapter 104 of the Tort Claims Act

Faculty with a 0% FTE at UTHSCSA and 100% FTE at VAH are covered by Federal Tort Claims Act and will not be covered by the Plan unless the member's service falls under a special/unique contract stating UTHSCSA will provide medical liability coverage

Name of Plan: The University of Texas System Professional Medical Liability Benefit Plan
(Policy # is N/A, Self insured through UTS, there is no private insurance carrier)

Address:
THE UNIVERSITY OF TEXAS SYSTEM
Office of General Counsel
201 WEST SEVENTH STREET AUSTIN, TEXAS 78701-2981
TELEPHONE (512) 499-4462 FAX (512) 499-4523

Allene D. Evans
Senior Attorney & Deputy Plan Administrator
Office of General Counsel

The University of Texas Health Science Center at San Antonio
Jack C. Park, J.D.
Chief Legal Officer
7703 Floyd Curl Drive
San Antonio, TX 78229-3900
(210) 567-2020 Fax (210) 567-3869

Kathy Geoghegan, R.N., B.S.N.
Director of Risk Management
7703 Floyd Curl Drive, Rn 428A
San Antonio, TX 78229-7837
(210) 567-2019 Fax (210) 567-3869

To purchase additional coverage at Physician/Resident's own expense:
UTS may need to approve the policy: Bill Beatty Insurance Agency visit website: http://www.bbi-tx.com/
This is NOT a referral/recommendation - you may find other coverage by searching the internet
Malpractice coverage based on type of student: Dental (Brown and Brown, Inc.), Medical (UT System), Allied Health or Nursing (Bill Beatty Insurance Agency)
This handbook summarizes coverage, exclusions, and responsibilities under The University of Texas System Professional Medical Liability Benefit Plan (Plan) and is to assist you in reporting incidents or claims. Coverage is subject to the terms, conditions, and limitations of the approved Plan and the interpretations thereof by the Board of Regents of The University of Texas System and/or the Plan Administrator.

All questions pertaining to the operation of the Plan should be referred to the Vice Chancellor and General Counsel (Administrator) or the Deputy Plan Administrator.

Daniel H. Sharphorn  
Vice Chancellor & General Counsel  
The University of Texas System  
210 West Seventh Street  
Austin, TX  78701  
(512) 499-4462  
dhsarphorn@utsystem.edu

Allene D. Evans  
Senior Associate General Counsel and Managing Attorney, Health Law  
Deputy Plan Administrator  
Office of General Counsel  
The University of Texas System  
210 West Seventh Street  
Austin, TX  78701  
(512) 499-4630  
aevans@utsystem.edu
PLAN LIAISONS

Questions pertaining to participation in the Plan may be directed to the following Plan liaisons who function as the directors of professional liability/risk management of the respective institutions. All incidents, notices of health care liability claims, and lawsuits should also be reported to the Plan liaison or designated risk manager.

The University of Texas at Arlington
John Hall
Vice President for Administration and Campus Operations
P.O. Box 19119
Arlington, TX 76019-0119
(817) 272-2102 Fax (817) 272-5805

The University of Texas at Austin
Patricia A. Ohlendorf, JD
Vice President for Legal Affairs
Department of Legal Affairs
PO Box R
Mail Code G4800
Austin, TX 78713
(512) 471-1241

Jamie Shutter
Director, University Health Services
P.O. Box 7339
Mail Code A3900
Austin, TX 78713
(512) 475-8349 Fax (512) 471-0898

The University of Texas at Dallas
Tim Shaw
University Attorney
Office of Administration, Room 2.412
800 West Campbell Road, AD35
Richardson, TX 75080
(972) 883-5291 Fax (972) 883-2212

The University of Texas at El Paso
Andrea Cortinas
Executive Director
Legal Affairs, room 403
500 West University Avenue
El Paso, TX 79968
(915) 747-5056

The University of Texas at Rio Grande Valley
Karen E. Adams, J.D.
Chief Legal Officer
2102 Treasure Hills Blvd
Harlingen, TX 78550
(956) 296-1416 (direct)

The University of Texas at San Antonio
Beth Wichman, M.D.
Executive Director of Student Health Services
6900 N. Loop 1604 West
RWC 1.500
San Antonio, TX 78249-0684
(210) 458-4142 Fax (210) 458-4151

The University of Texas Southwestern Medical Center
Joan Porter, J.D.
Director, Medical Risk Management
Office of Vice President for Legal Affairs
5323 Harry Hines Boulevard
Dallas, TX 75390-9172
(214) 648-6905 Fax (214) 648-6914

Cecilia Montoya, R.N.
Risk Manager
Office of Vice President for Legal Affairs
5323 Harry Hines Boulevard
Dallas, TX 75390-9172
(214) 648-6903 Fax (214) 648-6914

The University of Texas Medical Branch at Galveston
Carolee A. King, J.D.
Senior Vice President & General Counsel
Office of Legal & Regulatory Affairs
Suite 6.100 Administration Building
301 University Boulevard
Galveston, TX 77555-0124
(409) 772-1904 Fax (409) 772-5064

The University of Texas Health Science Center at Houston
Melissa Proko, J.D.
Vice President & Chief Legal Officer
P.O. Box 20036
7000 Fannin
Houston, TX 77225-0036
(713) 500-3268 Fax (713) 500-3275

Catherine R. Thompson, R.N., M.P.H.
Healthcare Risk Manager
P.O. Box 20036
7000 Fannin
Houston, TX 77225-0036
(713) 500-3268 Fax (713) 500-3275

The University of Texas Health Science Center at San Antonio
Jack C. Park, J.D.
Chief Legal Officer
7703 Floyd Curl Drive
San Antonio, TX 78229-3000
(210) 567-2020 Fax (210) 567-3669

Kathy Geoghegan, R.N., B.S.N.
Director of Risk Management & Loss Prevention
7703 Floyd Curl Drive, Rm 344AAB
San Antonio, TX 78229-7837
(210) 567-2019 Fax (210) 567-3669
The University of Texas M. D. Anderson Cancer Center
Steven R. Haydon, J.D.
Vice President and Chief Legal Officer
Legal Services – Unit 1674
P.O. Box 301407
Houston, TX 77230-1407
(713) 745-6633 Fax (713) 745-6029

Holly Rumbaugh, J.D.
Managing Legal Officer
Legal Services – Unit 1674
P.O. Box 301407
Houston, TX 77230-1407
(713) 745-6633 Fax (713) 745-6029

The University of Texas Health Science Center at Tyler
Terry Witter,
AVP/Chief Legal Officer
11937 US Highway 271
Tyler, TX 75708-3154
(903) 877-7704
INTRODUCTION

The University of Texas System Professional Medical Liability Benefit Plan (Plan) provides medical liability insurance for certain health care providers of The University of Texas System (System). This booklet contains general information regarding eligibility for coverage, covered claims, exclusions from coverage and limits of coverage.

ELIGIBILITY

The Plan provides liability indemnity for medical liability claims to its participants, subject to the terms and conditions of the Plan as approved by the U.T. System Board of Regents. "Plan Participant" includes:

1. Staff physicians and dentists appointed to the faculty of an institution of the System;

2. Residents and fellows enrolled at a U.T. medical or dental institution or school and participating in a patient-care program of the System;

3. Staff physicians and dentists appointed to the faculty of a medical school or hospital of the System on a part-time or volunteer basis who either devote their total professional service to such appointments or provide services to patients by assignment from the department chair;

4. Medical students, when participating in an approved patient-care program under the direct supervision of a faculty member;

5. Medical doctors employed in student health services at an institution of the System; and

6. System institutions against which a liability claim is made that arises from the treatment or lack of treatment by any of the above Plan Participants.

COVERED CLAIMS

A "medical liability claim" is a claim or a cause of action alleging treatment or lack of treatment that departs from accepted standards of medical care which proximately results in the injury or death of a patient.

In order to qualify as a "covered claim" the medical liability claim must arise from the participant’s employment, official duties, or training with the System. Treatment rendered in the performance of these official duties must occur within the United States, its territories or possessions, or Canada. For "medical liability claims" arising from treatment rendered in any other foreign country, however, specific additional international coverage must have been purchased and specific conditions of participation must be met. Note: For international coverage, lawsuits must be filed in the United States.
“Disciplinary and Licensing Actions” which are covered include any disciplinary, licensing, or similar administrative proceeding brought against a participant by the Texas Medical Board or Texas State Board of Dental Examiners that arises from a covered activity, except where a potential conflict of interest exists between the Participant and The University of Texas System or its institutions with regard to a potential or pending employment or administrative matter. In certain circumstances, out of state disciplinary proceedings may also be covered.

Coverage of participants for Disciplinary and Licensing Actions is limited to legal representation of the participant by an attorney in a proceeding brought against the participant by the Texas Medical Board or Texas State Board of Dental Examiners that arises from a covered activity.

Coverage provided by the Plan is on an occurrence basis, meaning that a participant is covered for all claims and lawsuits that arise from treatment, regardless of when the claim or lawsuit is filed.

**EXCLUSIONS FROM COVERAGE**

A complete list of exclusions is contained in the Plan document maintained by the Plan Administrator. The following is a partial list of coverage exclusions for medical liability claims as well as disciplinary and licensing actions:

1. Injury arising out of any illegal, dishonest, fraudulent, criminal or malicious act or omission;

2. Any claim or lawsuit based upon the violation of a state or federal law;

3. Injury arising out of any sexual conduct of the participant;

4. Injury caused while the participant is acting under the influence of alcohol or drugs;

5. Any claim or lawsuit arising from actual or alleged discrimination based upon race, religion, color, sex, national origin, age, or handicap against a patient or employee;

6. Property damage;

7. Punitive or exemplary damages;

8. Any claim or lawsuit arising out of professional services which occur after the termination of the faculty appointment, residency, or medical student status with the System;

9. Any claim or lawsuit arising out of professional services billed for by the participant but not deposited in a System institution practice plan, trust-affiliated foundation or certified not-for-profit corporation as approved by the Board;
10. Any claim or lawsuit arising out of professional services performed for professional fees, salaries, or other compensation by a participant outside of their employment, appointment or enrollment with the System.

**LIMITS OF LIABILITY OF THE PLAN**

These limits apply unless lower liability limits are set by law, in which case the lower limits apply:

- **Annual Policy Aggregate:** $30,000,000
- **Staff Physician:** $500,000 per claim / $1,500,000 annual aggregate
- **Resident:** $100,000 per claim / $300,000 annual aggregate
- **Medical Student:** $25,000 per claim / $75,000 annual aggregate

**Per Incident Limitation:** Liability is limited to $2,000,000 per claim, regardless of the number of the claimants or physicians involved in an incident.

For an additional premium, medical students may be eligible for additional coverage when enrolled in an approved “externship” outside of the State of Texas.

For an additional premium and upon meeting specific criteria, physicians may be covered while providing medical services internationally on behalf of UT System.

For an additional premium and upon meeting specific criteria, physicians may be eligible for additional levels of coverage for approved out of state medical services.

**Limitation on Disciplinary and Licensing Actions:** Up to $25,000 in costs and expenses incurred in connection with the investigation and defense of a single disciplinary and licensing action brought against the participant, unless there is a discretionary determination of necessity to exceed this limitation up to $35,000; and up to $100,000 for all such proceedings during an annual enrollment period.

**RESPONSIBILITIES OF THE PARTICIPANT**

**Procedure for Reporting Incidents**

Any incident that is not consistent with the routine operation of a hospital or clinic or the routine care of a particular patient should be reported to the U.T. health institution Plan liaison or designated risk manager, who will request a written report on behalf of the institution’s Professional Liability Review Committee and the Office of General Counsel.

Written reports requested by the institutional Plan liaison on behalf of the Office of General Counsel and the institution’s Professional Liability Review Committee are prepared in anticipation of litigation and are confidential under the privileges accorded to attorney-client communications and peer review committee investigations. Participants should
inform their department chair that they are reporting an incident to the Plan liaison. However, NO WRITTEN NARRATIVE REPORTS should be given to the department chair because the institutional Professional Liability Review Committee comprised of clinical chairs or their deputies, will request and review all narrative reports in order to conduct a confidential medical peer review of the incident. Reports of incidents involving a resident insured by an affiliated teaching hospital’s liability coverage will be referred to the hospital risk manager’s office.

Procedure for Reporting a Notice of Claim or Lawsuit

For your own protection and to comply with the conditions of this Plan, all written notices of claims or legal actions must be reported promptly. Time is of the essence in the proper disposition of any claim or legal action and FAILURE TO NOTIFY the Office of General Counsel via the Plan liaison or designated risk manager may JEOPARDIZE YOUR COVERAGE.

1. Whenever a participant receives notice of a health care liability claim or is served with a citation and petition the following steps should be taken IMMEDIATELY:
   a. Inform the department chair or deputy of the receipt of a notice of a health care liability claim or lawsuit.
   b. Proceed immediately with all legal papers to the Plan liaison or designated risk manager at your institution (see List of Plan Liaisons above) who will forward all documents to the Office of General Counsel. The Office of General Counsel, assisted by the institution’s Professional Liability Committee, Plan liaison and risk manager, will investigate the claim.
   c. Refer all further inquiries by the patient or his attorney to the Office of General Counsel via the Plan liaison or risk manager.

2. If a participant who is no longer employed by the System or enrolled in the Plan receives a notice of health care liability claim or citation and petition regarding an alleged incident that occurred while the participant was covered under the Plan, the participant should take the following steps:
   a. Advise the Plan Liaison or designated risk manager by telephone of such notice, or citation and petition. The Plan Liaison or designated risk manager will immediately contact the Office of General Counsel.
   b. As soon as possible, all legal documents should be forwarded to the Office of General Counsel via the Plan Liaison or designated risk manager.

Once a notice of claim is received or a lawsuit is filed, the participant, upon request of the institutional Professional Liability Committee and the Office of General Counsel may be asked to complete a narrative report.

Upon receipt of a citation and petition served upon a participant, the Office of General Counsel will select a defense attorney to represent the participant in the lawsuit. All legal
fees and expenses are paid by the Plan and are not deducted from the limits of liability coverage of a participant.

**SETTLEMENT DECISIONS**

The Administrator of the Plan (Vice Chancellor and General Counsel), has the ultimate authority to settle a claim or lawsuit, subject to additional approvals required by the Board of Regents. It is, however, the practice of the Office of the General Counsel to include the participant in any discussions of settlement of a claim where payment will require a written report to be made to the National Practitioner Data Bank.
Physician-In-Training (PIT)/ Licensure & The TMB
Physician in Training (PIT)

Physician-in-Training (PIT) Permit allows a qualified person to participate in a post graduate medical training or fellowship program to the supervised practice of medicine that is part of the training or fellowship program.

Before You Apply

Individuals considering applying for a PIT permit should use the links to the left to review the Eligibility Checklist and Sample Application to their applications. In addition, an applicant must obtain a TMB personal ID # from their training program and a third party indemnity program. The third party identification number is needed only if the program will be paying the application fee. For application process, contact Pre-Licensure, Registration and Consumer Services at (512) 305-7030.

Apply

Apply online using the link to the left. Permit applications that do not require supplemental forms and third party information business days and mailed to the mailing address indicated on your application. Verification of approved permits can be obtained from the IDM page within two business days of issuance.

Depending on your answers, some of the questions on the application will require you to download a supplemental form and party documentation requested. Your application will not be considered complete until all supplemental information is received. Only when all requested information has been evaluated and approved. Supplemental forms and third party information should always be submitted to the address indicated on the application.

After submitting an application, the fee and any supplemental forms, the next step is an initial review. Due to the large volume of applications, an initial review may take a minimum of 6 weeks. After the initial review, applicants are notified of any missing information needed to complete the processing of the application.

Document Retention and Submission: Documents submitted to and received by the board prior to the receipt of your application 6 months only. Documents can be sent by e-mail, fax, regular or overnight mail.

- e-mail to pit.applications@tmb.state.tx.us
- fax to (888) 550-7516 Attn: PITS (if less than 10 pages)
- Overnight and Regular mail - We recommend using one of the private overnight delivery services that allow tracking.

These services require delivery to a physical address and a phone number. Delivery by a private overnight service to our office will provide immediate on-line confirmation of delivery from the carrier.

When submitting forms and documents, we recommend using one of the private overnight delivery services that allow tracking.

Delivery to a physical address and a phone number. Delivery by a private overnight service to our physical address usually allows
online confirmation of delivery from the carrier.
Items mailed through the US Postal Service (regular, certified, express, or overnight), must be addressed to our mailing address the sender. A vendor signs for and delivers these items to our agency. Even if a tracking mechanism is used, the signature conl delivered to the mailing address will be that of a vendor employee, making confirmation of delivery to the TMB more difficult.

Are You Having Trouble Accessing the Online PIT Application?
Due to patterns of malware, certain countries are blocked from access to TMB online applications. PIT applicants residing in or to access the online application should do the following:
- Print a copy of the Sample PIT Application
- Complete the sample application and then work with someone in your program to enter the information into our online
- Complete a Third party application completion affidavit if you did not complete the online application or attestati

Contact Information

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<th>MAILING ADDRESS</th>
<th>FAX</th>
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<tbody>
<tr>
<td>Texas Medical Board</td>
<td>Texas Medical Board</td>
<td>(888) 550-7516</td>
</tr>
<tr>
<td>PRC, MC-240</td>
<td>PRC, MC-240</td>
<td>Attn:</td>
</tr>
<tr>
<td>333 Guadalupe, Tower III, Suite 700</td>
<td>P.O. Box 2029</td>
<td>E-MAIL</td>
</tr>
<tr>
<td>Austin, TX 78701</td>
<td>Austin, TX 78768-2029</td>
<td>PITAPPLICATION</td>
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<tr>
<td>Phone – (512) 305-7030</td>
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Applicants should note that issuing a PIT Permit to a physician shall not be construed to obligate the Texas Medical Board to issue permits or licenses. The board reserves the right to investigate, deny a permit or full license, and/or discipline a physician regis information was received by the board.

Reporting Requirements

Permit holders and Postgraduate Training Program Directors have requirements for reporting on certain situations, actions taken by the program within 30 days of their occurrence or of becoming aware of their occurrence. Failure to report may result in administrative violation against the permit holder and/or the program director. The forms for reporting are found in the quick access sections.

Permit holders must report:
- the opening of an investigation or disciplinary action taken against you by any licensing entity other than the Texas Medical Board;
- an arrest, fine (over $250 excluding traffic violations), charge or conviction of a crime, indictment, imprisonment, placement of deferred adjudication; and
- diagnosis or treatment of a physical, mental or emotional condition, which has impaired or could impair your ability to practice.

Postgraduate Training Program Directors must report:
- if a physician did not begin the training program as scheduled;
- if a physician has been or will be absent from the program for more than 21 consecutive days (excluding vacation, family emergency, or military leave) and the reason(s) why;
- if a physician has been arrested after beginning training in the program;
- if a physician poses a continuing threat to the public welfare as defined under Tex. Occ. Code §151.002(a)(2), as amended;
- if the program has taken final action that adversely affects the physician’s status or privileges in a program for a period of 1 year;
- if the program has suspended the physician from the program; and
- if the program has requested termination or terminated the physician from the program, requested or accepted withdrawal of program, or requested or accepted resignation of the permit holder from the program and the action is final.

Permit holders or program directors with questions about reporting requirements can contact Pre-Licensure, Registration and Licensure at (888) 550-7516, or by e-mail at pit.applications@tmb.state.tx.us.
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<th>Who</th>
<th>What</th>
<th>When</th>
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| 1    | Postgraduate Training Program                 | • Verifies identity.  
• Verifies graduation or scheduled graduation from medical school prior to training program start date.  
• Accepts and enrolls applicant in to the program.  
• Sends TMB the completed PIT Permit Applicant Submission Excel Spreadsheet and Certification by email to: pit.applications@tmb.state.tx.us.  
• If program is interested in paying the application fees, submit a request to pit.applications@tmb.state.tx.us to be assigned a 3rd party payer ID number or for questions about your password. | Between 90 and 120 days before program start date |
| 2    | TMB                                           | • Uploads data from the spreadsheet to TMB database.  
• Creates TMB personal ID numbers for each applicant.  
• Returns spreadsheet by e-mail to the program director/designated contact, with the TMB personal ID numbers assigned to each applicant.  
• If requested, assigns program third party payer ID number and emails instructions to program contact. | Within 5-7 business days                   |
| 3    | Postgraduate Training Program                 | • Provides each applicant with their TMB personal ID number.  
• Provides each applicant with their ACGME/AOA/TMB Program ID #.  
• Provides applicant 3rd party payer ID # and instructions to use it.  
• Pays for applicants if using bulk payment.  
• Applications for a physician-in-training permit can be submitted to the board no earlier than 120 days prior to the program begin date in Texas to ensure the application information is not outdated. | As soon as possible after receipt of the TMB personal ID number |
| 4    | Each Texas Licensed physician supervising Texas rotations Required ONLY for applicants completing a rotation in Texas as part of their out-of-state training program. | • Submits statement to TMB (pit.applications@tmb.state.tx.us) that certifies:  
  o the facility at which the rotations are being completed  
  o the dates the rotations will be completed in Texas*  
  o that the Texas on-site preceptor physician will supervise and be responsible for the applicant during the rotation in Texas  
• Applications for a physician-in-training permit can be submitted to the board no earlier than 120 days prior to the rotation begin date in Texas to ensure the application information is not outdated. | No later than 60 days before the rotation start date |

*Rotator permits are limited to the dates of the rotation in Texas. The permit will reflect the name/address of the out of state postgraduate training program and not the Texas program/rotation site.
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<th>No.</th>
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| 5   | Applicant | - Logs on to [https://applications.tmb.state.tx.us/Pl/ident1.aspx](https://applications.tmb.state.tx.us/Pl/ident1.aspx)  
- Completes online application.  
- Applicant must have their TMB personal ID number; Program ID number; Payment Information/3rd party payer ID ready in order to complete application.  

**Note to payers:**  
You will have 15 days to pay for a transaction once a physician submits an application. After that time, the application will drop and the physician will have to reapply online. |
| 6   | PIT Permit Online Apps | - Previous day applications are transmitted daily to TMB, unless applicant applies on a weekend or holiday, electronic file may not be sent until next business day. |
| 7   | TMB | - Updates TMB database with information from the application file |
| 8   | TMB | - Reconciles incoming applications. A permit is issued if applicable or the application is assigned a licensure analyst.  

The processing time frame is increased for applicants that are required to furnish supplemental documentation or whose application will require an escalated review of their application. |
| 9   | TMB | - Sends daily fax report to programs informing programs of the applicants who have been issued a permit.  

**Note:** The TMB licenses physician license applicants approximately every two weeks. If a PIT Permit Holder is licensed, you will be sent a fax report advising you of who was licensed along with their license number. The PIT Permit will be terminated the same day an individual is licensed. |
Hello all,

I’ve received inquiries about changes to the PIT permit processing documents and templates for 2017. You can use the 2016 documents and templates this year but here is some information for you!

Helpful reminders:
- Make sure your spreadsheet begins on Line 2. If you’ll recall the first spreadsheet I sent out last year started on line 453! This throws the spreadsheet processing program for a loop and freezes up. So just double check the sheet starts on Line 2.
- Don’t recycle the Processed spreadsheet you get back from the TMB. Start with a new spreadsheet because the headers have instructions and drop downs for data entry.
- Please don’t enter N/A in a field that doesn’t apply to the applicant, for example an ECFMG number for a domestic medical school graduate. And please don’t enter any other degree than MD or DO for example PhD or MBBS.
- Encourage your applicants to submit their lacking items/documents via email to pit.applications@tmb.state.tx.us or by fax to (888)550 7516, Attn: PIT Permits. In both instances they need to include their name and TMB Personal ID number.
- You must have a signed release on file with the TMB in order for Board staff to give you information about an applicant’s file.

The following is information and documentation regarding the PIT Permit application process.

Current PIT Permit Application Documents are updated and attached:
Once the submission has been processed, we will return the TMB Personal ID Number to the program director/coordinator along with the link to the online application along with any other important information.

1) PIT (Physician in Training) Permit Application Process v2017 (see #8 for update regarding processing time frames)
2) PIT Spreadsheet Instructions v2016
3) Blank spreadsheet for the program’s use v2016
4) Authorization to receive correspondence for residents - optional v2016 (Also see Other Important Information section below)
Problems with Online Application:
If your residents/fellows have problems with the online application or bulk payment system, the following will be needed to assist you in resolving the problem:

1) Be sure the applicant was given the correct application link. Access the application here: https://applications.tmb.state.tx.us/PI/ident1.aspx
2) Take screen shots of the page/place where the problem is occurring.
3) Take a screen shot of error message.
4) Send all to pit.applications@tmb.state.tx.us along with the applicants name/TMB Personal ID.

Bulk Payment Payor:
If you are a bulk payment payor and did not receive the new information in 2013, attached is the bulk payment manual. If you need your password, please contact us via email at pit.applications@tmb.state.tx.us.

Military Fee Waiver Requests:
The home program must send in a spreadsheet submission listing any military service individuals that qualify for the waiver of the PIT application fee. The individual must complete and return a Military Fee Waiver request form along with a copy of their orders to the program and current military ID. This is the link to the MFW form: http://www.tmb.state.tx.us/page/licensing-military-fee-exemption

Gmail email users:
Email received from personal and business Gmail accounts may be undeliverable/slow to come through to the TMB. Use a different (non-Gmail) email account if possible.

IMGs with visa issues:
PIT permit applicants that are identified as a H1B holder are sent a letter that they can send with their visa application to the USCIS (United States Citizenship & Immigration Services) formerly the INS. Below is an excerpt from the letter for PIT permit applicants.

This serves as confirmation that XX XXXX, MD is eligible for a Physician’s in Training Permit effective July 1, 2017 to June 30, 2020 to perform her clinical duties at Driscoll Children’s Hospital, Corpus Christi, TX, Dept of Pediatrics. The permit will be issued upon approval of her application for a training permit. Applications for a training permit can be submitted no early than 120 days before the program begin date. The permit is effective for the length of the postgraduate training program as reported by the training program.

Other Important Information:
Ø All incoming spreadsheets, extension requests, new permit requests and applications are processed in date order received.

Ø This is link to the PIT Permit menu on the TMB website: http://www.tmb.state.tx.us/page/pit-overview
  o Sample Application available
  o Link to supplemental forms including Name Change Form and Change of Address Form
  o Instructions for individuals who cannot apply online because they are in a country that is blocked from using the TMB online systems.

Ø The Authorization to receive correspondence for residents (#4 in Current PIT Permit documents section) is not a release for TMB staff to give information to a 3rd party. It’s only to receive correspondence with the exception of the PIT permit. The permit is sent to the mailing address the applicant listed on their application.
Sample Release of Information Form: [http://www.tmb.state.tx.us/dl/E14E552F-C26F-F2DD-19D2-DD8736054723](http://www.tmb.state.tx.us/dl/E14E552F-C26F-F2DD-19D2-DD8736054723)

Ø Requests for a new permit for someone switching programs within the same institution: Please follow the attached “How To” to make common PIT permit requests. Do not put these requests on a spreadsheet.

Ø PIT Permits are not transferrable between institutions or between two different departments/specialties within the same institution.

Ø Any questions that relate to PITs need to be sent directly to pit.applications@tmb.state.tx.us and not to an individual’s email box.

Ø A message from the Executive Director regarding Faculty Temporary Licenses remains in force (see below). Please share this with the representatives in your organization that handle FTLs.

Thank you!
Nori Peterson

Nori C Peterson
Licensure Division, Academic Specialist - Licensing Dept
P O Box 2029
Austin, TX 78768-2029
(512) 305 7030
(888)550 7516 Fax
[www.tmb.state.tx.us](http://www.tmb.state.tx.us)

**Please note:** The Texas Medical Board is experiencing the highest ever volume of all applications at this time. Licensure has prioritized processing applications over all other tasks, including communication. LIST messages, emails, and voicemails will be returned within 3 to 5 business days. Please do not leave multiple messages in different formats.

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**Texas Medical Board**

Dear Department Chair:

I am writing to announce a policy change that may affect your processes. Effective immediately, faculty temporary license applications must be submitted to the Board at least 45 days prior to the date required for issuance. Previously the standard was 90 days. A problem developed where very little processing time was provided upon application from an institution, and multiple applications arrived with urgent requests to expedite. The new requirement will be 45 days, and staff will need the full 45 days between the months of April and August to process and complete an application. Although we would like for you to always give us at least 45 days of lead time, in general, we can process these applications more quickly between September and March. Requests to expedite future faculty temporary license application submissions
will not be granted, except in extreme cases where a hardship can be demonstrated, and inability to submit with more lead time can be proven. I will be personally reviewing those requests.

In addition, the Board, at its December 6, 2013 meeting, directed staff to provide a reminder of the delineation of duties under a faculty temporary license.

A faculty temporary license holder must hold a salaried faculty position equivalent to an assistant professor-level or higher working full-time in an accepted institution; or hold a faculty position equivalent to an assistant professor-level or higher, working at least part-time; be on active duty in the United States military; and be engaged in a practice under the faculty temporary license that will fulfill a critical need of the citizens of Texas.

Recently the Board has reviewed cases where a faculty temporary license holder did not work full time in the faculty position, but was actively working in a fellowship. In order to prevent eligibility issues for potential applicants, it is imperative that practice under a faculty temporary license be appropriate to the license.

Thank you for your assistance,

Scott Freshour, JD
Interim Executive Director
Texas Medical Board

---

Improving the Health of All Texans

Texas Medical Association
www.Texmed.org
401 W. 15th Street
Austin, TX 78701

[All users of the TMA e-mail lists agree to abide by the Texas Medical Association E-mail List Rules and Conditions. For complete text of the rules and conditions, see http://www.texmed.org/emailpolicy/ ]
Instructions
How to use and send the PIT (Physician in Training) Permit Application Spreadsheet

1. Download and save the TMB PIT Permit Application Submission Spreadsheet.
   a. Double-click on the attachment open the PIT Permit Application Submission Spreadsheet.
   b. Click on File, then on Save As.
   c. In the Save As box, select the appropriate location for saving the file.
   d. Leave the file and file type as it already appears in the dialog box.
   e. Close the saved PIT Permit Application Submission Spreadsheet.
   f. Word or Adobe .pdf copies of the spreadsheet cannot be submitted for processing.

2. When ready for use, open the spreadsheet, choose File, Save As and name it with the name of your institution, specialty and today’s date. Use a new spreadsheet for each submission.
   Do not submit an altered version of the TMB spreadsheet or one that has already been processed. An unprocessed spreadsheet will be labeled as PIT Spreadsheet v2016 at the bottom of the page.
   All of the data on your PIT Permit Application Submission Spreadsheet will be used to create an electronic application and must match with the applicant’s online submission, so be very careful that your data entry is correct. Please advise your applicants to do the same.

3. You’re ready to begin data entry.
   a. There are 13 columns or data fields to be collected.
   b. Enter a row of information for each applicant, with the data for each applicant in the appropriate column.
   c. Click on cell A2 to begin data entry. Do not skip rows.
   d. You may move to the next column on the same row by using the TAB key.
   e. Start a new row for each applicant.
   f. Information about each column of data is shown below.

ACGME, AOA or TMB Program ID#
Enter the numeric code for the specific program. Do not enter the dashes – only numbers; the dashes should display after entry.
- AOA programs add 503 to the beginning of your program number.
- Out of state rotators use their home program’s ACGME or AOA program ID.
- Canadian rotators: you can leave this field blank as the TMB will assign the program ID while processing your submission.

PIT Type
This column contains a drop down list and you must select PIT, ROT or CP.
- PIT = Initial PIT Permit
- ROT = Rotator Permit (Initial and Subsequent)
- CP = Institution Change PIT Permit (use if the applicant has had a PIT permit at another institution and is now joining your institution and the other institution permit is still active)

Important Note: PIT holders changing programs within the same institution do not need to apply for a new PIT permit if the request for a new permit is made before the current permit
expires. Follow the “How To” after the end of these Instructions to see if the resident qualifies and do not submit a spreadsheet for these requests.

**TMB personal ID #**
- If the PIT applicant has had a previous application, permit or license with TMB, the applicant should already be assigned a TMB personal ID number.
- Please make every effort to enter this number, if it exists. It will help to avoid duplication in TMB’s system and delay in issuing the permit.
- If you do not know the number, you can still send your submission without it.

**First Name, Middle Name**
- Enter the first and middle names of the PIT applicant.
- This name field may ultimately be overwritten if the PIT applicant supplies a variation of the name when applying online. However, it will be useful to TMB in the event that other fields don’t match as expected.
- Do not use periods in the names.

**Last Name**
- Enter the last name of the PIT applicant. If double last names, you can use a hyphen but it should match how the applicants enters their name online.
- This name field may ultimately be overwritten if the PIT applicant supplies a variation of the name when applying online. However, it will be useful to TMB in the event that other fields don’t match as expected.

**Legal Name Change form on TMB website:** [http://www.tmb.state.tx.us/page/pit-supplemental-forms](http://www.tmb.state.tx.us/page/pit-supplemental-forms)

**Suffix**
- This column contains a drop down list and you may select JR, SR, II, III, IV or V.
- Leave the cell blank if an applicant has no suffix on his or her name.

**Degree**
- You must select MD or DO. Do not enter any other degree such as MBBS. A MBBS is considered to be the equivalent of a MD degree.

**SSN**
- Enter the PIT applicant’s social security number, if one exists.
- If the applicant receives a SSN after they apply, they must report it to the TMB at: [pit.applications@tmb.state.tx.us](mailto:pit.applications@tmb.state.tx.us).
- The entire SSN is needed not just the last four digits.
- Do not enter dashes – only numbers; the dashes should display after entry.

**Date of Birth (DOB)**
- Enter the date of birth as mm/dd/yyyy.
ECFMG #
- If the PIT applicant is an international medical graduate, enter the applicant’s ECFMG number.
- Do not enter dashes only numbers.
- Leave the cell blank if the applicant does not have an ECFMG number. Do not enter N/A or zero.

Training Program Start Date*
- Enter the date the applicant will start the training program.
- Use slashes (/) and the format mm/dd/yyyy. An example is 07/01/2015.
- *Out of state and Canadian applicants use, use the start date of the rotation in Texas.

Training Program Completion Date*
- Enter the date the applicant is scheduled to complete the training program.
- Use slashes (/) and the format mm/dd/yyyy. An example is 06/30/2019.
- *Out of state and Canadian applicants use, use the completion date of the rotation in Texas.

H1B Visa Letter Needed – for Texas residents/fellows only
- Select Yes from the drop down list if an INS letter is needed. If not, skip this cell.
- If Yes is entered in this column, an INS letter will be returned with the processed spreadsheet submission.

4. After you have entered a row of data for each applicant, save the PIT Application Submission Spreadsheet one last time and close it.

5. Send the PIT Application Submission Spreadsheet to the TMB at pit.applications@tmb.state.tx.us as an attachment. Do not send to an individual’s email box.

6. Requirements for acceptance of the PIT Application Submission Spreadsheet (follow each step to avoid rejection of your submission!):

   a. The e-mail must come from the director of medical education, the chair of graduate medical education, the program director, or (if none of the previously named positions is held by a physician) the supervising physician of the postgraduate training program.

   b. We will also accept the spreadsheet in an e-mail from a staff member, so long as the director of medical education, chair of graduate medical education, the program director, or, if none of the previously named positions is held by a physician, the supervising physician of the postgraduate training program is copied on the email and the appropriate selection is indicated in the certification.

   c. In the body of the e-mail, the following certification statement must be included:

      I, (insert name here), certify that I am (select one of the following)
      ___ the chair of graduate medical education
      ___ the program director
      ___ if none of the previously named positions is held by a physician, the supervising physician of
the postgraduate training program, or
the (Housestaff Coordinator or appropriate title), that I am acting on behalf of (insert name here) who is the (chair of graduate medical education/program director/supervising physician), and that the named individual has authorized me to make the following certification. I am including the named individual in this email.

This information is submitted for (insert the name and specialty/department of your program).

I certify that:

- the program meets the definition of an approved postgraduate training program outlined in Board Rule 171.3 (a)(1) (2) and (4));
- the applicant(s) listed on the attached PIT Permit Applicant Submission Spreadsheet have been credentialed by the program to include verification of identity, and verification of medical school graduation;
- the applicants listed on the PIT Permit Applicant Submission Spreadsheet have met all educational and character requirements established by the program and have been accepted into the program;
- the program director is aware of his or her responsibilities under Chapter 171.6 of the board’s rules relating to duties of program directors to report certain circumstances within thirty (30) days of knowledge of the circumstances for any physician-in-training permit holder; and,
- the program has received a letter from the dean of each applicant’s medical school which states that the applicant is scheduled to graduate from medical school before the date the applicant plans to begin postgraduate training, if the applicant has not yet graduated from medical school.

Sample PIT Permit Application Submission Spreadsheet

![Spreadsheet Image]

Feb 2016/41
How to Submit Common Permit Requests
Do not send these requests in a spreadsheet!!

*Expiration Date Extensions  *Program Changes within Same Institution  *Placing in Research Status

General Instructions:
For any of the requests covered here, send an email to pit.applications@tmb.state.tx.us with the details listed below.

The program director must be copied on the request. Please do not submit a spreadsheet for these requests.

Request for Permit Expiration Date Extension
Same program and must be requested before permit expires…

Include the following details in the email to pit.applications@tmb.state.tx.us:
- Name of permit holder (exactly as displayed on permit)
- Permit holder’s date of birth (mm/dd/yyyy)
- TMB ID#
- New program/expiration date (mm/dd/yyyy)
- Reasons for extension (Ex: make up time off)

Request for New Permit Due to Program Change
Same institution and must be requested before current permit expires…

Include the following details in the email to pit.applications@tmb.state.tx.us:
- Name of permit holder (exactly as displayed on permit)
- Permit holder’s date of birth (mm/dd/yyyy)
- TMB ID#
- Current program ID number
- New program ID number
- New program/permit begin date (mm/dd/yyyy)
- New program/permit end date (mm/dd/yyyy)
- Reasons for change (Ex: progression into a sub-specialty)

Note about Website Verification: The website verification system can only display the most current permit issued. A new permit may be issued prior to the begin date, and thus display, although the current permit is still in force. Feel free to verify current permit by phone or in writing.

Request to Place Permit in Research Status
Same institution and we must receive (a) request before research begins and (b) notice before research ends…

Include the following details in the email to pit.applications@tmb.state.tx.us:
- Name of permit holder (exactly as displayed on permit)
- Permit holder’s date of birth (mm/dd/yyyy)
- TMB ID#
- Current program ID number
- Research begin date (mm/dd/yyyy)
- Research end date (mm/dd/yyyy)
Authorization for TMB (Board) to correspond with programs

Note: Programs that certify that they are authorized by each applicant to allow TMB to correspond with the program about the contents of the applications (lacking letters, permits, etc.) rather than the applicant, must submit the following statement **one time** to the board, either by e-mail to pit.applications@tmb.state.tx.us or fax to 1-888-550-7516.

Please be aware that this statement will apply to **all** applicants in the specified program from that point forward. If you do not have this type of authorization on file for **every** applicant in the program and you submit this statement, your program might receive confidential information and you would be liable for the consequences. If you only occasionally receive such authorizations from applicants, **do not** submit this statement.

Also be aware that this is not an authorization to release information to any third party.

I, (insert name and title), certify that (insert program name and ID number) has authorizations on file from **all** applicants for Physician In Training permits to receive **all** correspondence from the Board intended for the applicant from this point forward. I understand that I must notify the board immediately if this authorization for **any** applicant ceases to exist.

Date: ____________________
Residents Switching from Permits to Licenses

Be aware that:

- You must inform UHS as soon as the trainee obtains their Full Medical License
- Proof of application for the resident’s DEA certificate has to be received by UH’s Professional Staff Services within 2 weeks of the license issue date
- Residents have 90 days from the issue date to obtain the DEA certificate before UHS removes their prescriptive authority
- Add the license number to Ni and remove the permit number
NI-Required Documentation
Ni – Required Documentation

Personnel Data:

Entered by GME Office:

First name: as listed on most current Social Security card

Last name: as listed on most current Social Security card

Middle Name: as listed on most current Social Security card

Training records: Resident’s UTHSCSA program with start and end dates that coincide with contract dates each year; LOA’s (unpaid leaves) and extensions must be provided to the GME so that the training record can be updated accordingly. These must be coordinated with UHS in most cases.

Initial program – program resident entered the very first year out of med school; generally is whatever resident matched into (beware of simultaneous matches)

Post Graduate Year – total number of years of post-graduate years completed plus 1

Status – Year in Program; corresponds to status on Resident Contract

SSN – Never a temporary number

Medical School: if they attended multiple medical schools, the one they graduated from

Med school graduation date: data on diploma

School Code (CMS)

ECFMG IRIS date: USMLE Step 2 Clinical Skills (CS) pass date

Employer: the paymaster and administer of benefits. In most cases, this will be UH unless the person is paid by the military or on an H1B visa

DOB

Gender

Race

Ethnicity

Degree (credentials)

Training record

The Program must make the GME Office and UHS Professional Staff Services aware of any deviation from the training record, such as an LOA without pay and/or subsequent extension of contract year.
Entered by Program:

- Picture of resident
- Primary email: **must be UTHSCSA email address**
- Pay source: salary line for the resident; must be entered annually and align with contract dates
- Pager number
- Permit or License Number – must be entered into the Permit field, regardless of whether the person has a permit or a license
- Local address

Rising Chief residents should also be denoted in Ni every academic year.

*The information in the modules below is also the responsibility of the program.*

**Academic Year:**

An academic year matching a program’s rotation intervals must be entered annually.

**Block Schedule:**

A block schedule for each resident must be entered for each resident and fellow prospectively. These should be entered into Ni before July first for that academic year. This is a *program responsibility*. A block schedule must also be entered for military and clinical rotators when they are doing a rotation through your program. LOA’s must be logged in times of unpaid leave.

**Rotation Breakdowns (IRIS):**

An annual audit of rotation breakdowns is performed by the GME Office. Rotation breakdowns involve the amounts of patient care and didactics that comprise rotations and where those activities physically take place. Programs must be knowledgeable of these changes and the effective date of these changes and able to report them correctly to the GME Office. Between audits, programs must report any changes in locations or changes in percentages of didactics vs. patient care to the GME Office. Failure to produce correct information could constitute Medicare fraud.
Duty Hours:

Residents are required to log their daily duty hours contemporaneously based on duty type. Residents are responsible for logging every work day in addition to scheduled days off and vacation. Coordinators must ensure that logs are kept current and that logs are completed by the first day of the month for the prior month. If a violation results, the program is responsible for investigating the violation and ensuring that a cause and comment (explanation of reason for violation) are logged for the violation.

Program Administration:

Programs must enter their program leadership such as PD, APD, and personnel such as PC into Ni in the Program Information area.

Program must denote Core Faculty and CCC Members.

Program must choose their Participating Sites to align with the information in ADS.

Scholarly Activity of Residents (Portfolio):

Programs must ensure that residents enter all scholarly activity that relates to patient care and/or quality improvement in the Portfolio module using the “QI/PS Form.”

Onboarding:

Trainees must complete all assigned activities in Onboarding.

Annual Program Evaluation (APE):

Programs must complete the APE form in Ni by the first of the month in which it is due.

Procedure Logger:

Procedure logging is not required for any resident in Ni unless the program requires it. Levels of supervision, however, must be denoted for any bedside procedures that the residents/fellows can perform without direct supervision.
Adding a Payroll Record

For purposes of this task, it is necessary to define two terms:

**Employer:** The Employer is the entity who issues a paycheck and administers benefits for a trainee. Most UTHSCSA-sponsored residents and fellows are “employed” by UHS. Active military members are employed by the Military, and H1-B visa-holders are employed by UTHSCSA. Just a handful of Podiatry residents are VA-employed.

**Funding Source:** Funding source is the entity that provides the money for a resident’s salary line. Our residents are funded by UH, the VA, Santa Rosa, Methodist, Baptist, Department funds, grants, and other sources.

Creating a Payroll Record in Ni entails specifying both an employer and a funding source for each resident’s training period.

If a resident has the same funding source throughout his/her entire residency period, that person will only need one Payroll record. If a resident will be funded by UH one year and VA the next, a payroll record will need to be added for each year of training.

Please be sure to differentiate between “Christus Santa Rosa Healthcare” and “CHOSA – Children’s Hospital of SA.”

If you do not find the funding source you are looking for, please contact Wendy Malone so that it may be added.

TIP: Follow the directions below, and add nothing extra.
To enter a payroll record:

1. Click “Payroll” from the upper right quadrant of the resident’s/fellow’s Personnel Data record.

To enter payroll records:

2. If no information is entered, click Add a new Payroll Record. If years are entered already, you will need to edit each year by clicking on the pencil next to the year you wish to edit.

Alternatively, you may delete all records already entered and start from scratch.
3. Add start and end dates for the period you wish to enter. Remember, if a resident is funded by the same entity throughout his/her entire training period, your start and end dates can reflect the entire residency/fellowship period.

   [Start Date: 7/1/2014, End Date: 6/30/2015]
   Employer: UHS
   Compensation Status:
   Add Funding & Compensation
   Add Notes
   [Save, Cancel]

4. Add the appropriate Employer. If you do not see your trainees’ employer, contact Wendy Malone. Follow the instructions on page 1 for Employer.

5. Click “Add Funding & Compensation.”

6. Click the little “x” that the arrow is pointing to below to collapse the green area. Click “Yes” when asked if you are sure you want to remove the record in the pop-up box. Clicking any other “x” than the one to which the arrow is pointing will remove the funding source drop down, which you will need for the next step.

7. Choose the resident’s funding source. If the resident is funded by one entity, indicate that the FTE is 1.0 as in the screen shot above. If the person is funded by multiple sources (UH 50% and VA 50%, for instance), you will need to enter multiple funding sources. In the case of 50% UH funding and 50% VA funding, you would enter “UHS” and “.5” of an FTE and create another funding source by clicking on “Add Funding Source,” directly under the Funding Source drop down box. In the case of an additional 50% VA funding, you would enter “South Texas Veterans Health System” as the funding source and “.5” in the FTE box.

8. Don’t forget to Save!
Univ. Of Texas Health Science Center, San Antonio

Log a Scholarly Activity

*QI/PS/Scholarly Activity

Logging activity on behalf of Lorne Blackbourne

* Date of log

* Type of Activity
  - Quality Improvement/Patient Safety project
  - Book chapter
  - Peer-reviewed publication
  - Non-peer-reviewed publication
  - Committee membership
  - Presentation
  - Poster presentation
  - Submission of incident/occurrence report
  (put NA for title & description of activity below)
  - RCA attendance and contribution
  - Participation in GME review (APE, PPR, SPR)
  - CS&E participation
  - CS&E graduation
  - M&M (substantial contribution)
  - Other

* Title of Activity

* Short Description of Activity

Remaining Characters: 8,000

Date of Activity

Type of Approval
  - IRB
  - QIRC
  - Other
  - NA

Date of Approval

Was Project Published
  - Yes
  - No

PubMed Search

If not found in PubMed Search, please specify publication:

If presented, organization where presentation was given

Remaining Characters: 8,000

Name of faculty mentor
Names of co-authors/team members for project

If QI/PS project, facility at which project implemented
If QI/PS, select all that apply:
- Meets QI/PS goals of participating site
- Baseline data collected
- Action items developed
- Recommended actions for implementation
- Implementation monitored for success
- Multi-disciplinary teams from facility involved

Names and roles of interprofessional members

If you serve on a committee, please identify committee.

Dates of committee membership
Additional information:

Remaining Characters: 8,000

* required

Core Competencies

- Patient Care
- Medical Knowledge
- Systems-Based Practice
- Practice-Based Learning and Improvement
- Professionalism
- Interpersonal and Communication Skills

Uploaded Files

Upload Files

Contributors

Add Contributors

Save    Cancel
UHS’s Leave Policies & Procedures
MATERNITY LEAVE

It is in the best interest of the department and house staff to notify Professional Staff Services in advance of an expected maternity leave. Notification should be provided in the form of a memo signed by the Program Director and shall include the following information:

- Expected maternity leave start date
- Expected Return date
- Breakdown of leave to be utilized
  - Sick Days
  - Vacation Days
  - Leave of Absence (LOA) without pay
- If this leave will require an extension of the house staff’s training contract, indicate the new contract end date

If advance notification is not provided, or the maternity leave start date changes, then notification shall be emailed to Professional Staff Services by the Program Coordinator immediately upon the beginning of the maternity leave, whether the house staff has leave available or not.

Professional Staff Services will notify Human Resources Benefits of any maternity leave so that the FMLA/Medical Leave process can be started. It is the expectation of University Health System, that house staff respond in a timely manner to any requests for information from Human Resources.
Please be aware that house staff employed at UHS for less than a year do not qualify for FMLA coverage. However, notification of leave is still mandatory. HR will work with the house staff to determine what leave options are available to them.

House Staff cannot return to their regular duties until they have provided Human Resources with a clearance to return to work. HR will notify Professional Staff Services when this has been done.

**MEDICAL LEAVE**

Notification of a house staff that will require Medical Leave of Absence shall be provided to Professional Staff Services immediately upon becoming aware of the need for leave. Initial notification can be provided by email and followed by a formal memo signed by the Program Director. The memo shall include the following information.

- Medical Leave start date
- Expected return date (if known)
- Breakdown of leave to be utilized
  - Sick Days
  - Vacation Days
  - Leave of Absence (LOA) Without Pay

Professional Staff Services will notify Human Resources Benefits of any medical leave so that the FMLA/Medical Leave process can be started. It is the expectation of University Health System, that house staff respond in a timely manner to any requests for information from Human Resources.

Please be aware that house staff employed at UHS for less than a year do not qualify for FMLA coverage. However, notification of leave is still mandatory. HR will work with the house staff to determine what leave options are available to them.

House Staff cannot return to their regular duties until they have provided Human Resources with a clearance to return to work. HR will notify Professional Staff Services when this has been done.

Upon return from Medical Leave, the department shall notify Professional Staff Services if the leave will require an extension of the current training contract.
EARLY TERMINATIONS

If any housestaff (funded or non-funded) is terminated or resigns prior to the completion of their training contract, the training program shall immediately notify Professional Staff Services by email so that ID badge access and computer access can be deactivated.

The email notification shall be followed by a UHS Departing Form with the effective date of termination/resignation. The form shall be accompanied by a copy of the resignation letter submitted by the house staff or, in the case of termination, the reason for the termination.

Professional Staff Services will notify Human Resources of the termination/resignation so they can be removed from payroll.

Failure to notify Professional Staff Services of early terminations/resignations may result in the house staff being overpaid and having to reimburse funds to University Health System.

DISCIPLINARY ACTIONS NOTIFICATIONS

It is a responsibility of Professional Staff Services to safeguard our patients and patient information in the event that a house staff is removed from clinical duties. Therefore, any disciplinary actions taken by the training departments that require removal of the house staff from patient care responsibilities, must be reported immediately to Professional Staff Services so that access to the hospital facility and computer system can be inactivated pending outcome of the disciplinary action.

In these cases, further information may be requested by the Director of Professional Staff Services to determine if the house staff shall be allowed to return to clinical duties at University Health System facilities.
GENERIC TEMPLATE FOR NOTIFICATIONS OF EXTENDED LEAVE

[Date]

To: University Health System  
   Professional Staff Services

From: Program Director/Program Coordinator  
      Dept. of [Department]

Re: [Maternity or Medical] Leave – [House Staff Name]

Effective [Date], [Resident Name] began [state type of Leave]. Dr. [Name] will utilize his/her leave as follows:

   Sick Leave – from [Date] to [Date] (# days)  
   Vacation Leave - from [Date] to [Date] (# days)  
   LOA Without Pay – Beginning [Date]

Dr. [Name] is expected to return to work on [Date]

{Include one of these statements below:}

We anticipate that Dr. [Name] will have to extend his/her training year until [Date]

We anticipate that Dr. [Name] will not be required to extend his/her training year.

**Please note that extensions must be completed at the end of the training year contract in which the leave was taken.
UNIVERSITY HOSPITAL
House Staff Physician's Leave Form

FUNDING:  ☐ UHS  ☐ VAH  ☐ UTHSC  ☐ Military  ☐ Santa Rosa

NAME: ___________________________  DEPARTMENT/DIVISION: _______________________
(Last/First/Middle)

MONTH/YEAR: ______________________  ASSIGNED LOCATION: ______________________

<table>
<thead>
<tr>
<th>DAY</th>
<th>DATE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</td>
</tr>
</tbody>
</table>

CODES: V=Vacation  M=Meeting  NC=No Call/No Late Stay  AR=Authorized Rotation
S=Sick          L=Leave of Absence   RC= Request Call  O=Other

☐ MEETING/CONFERENCE/SEMINAR (type and location):

☐ AUTHORIZED ROTATION (name and address of facility):

☐ OTHER (specify – licensure exam, board exam, jury duty, military reserves and location):

☐ LEAVE OF ABSENCE (temporary disability, maternity, personal – accompanied by memo of explanation by Program Director)

__________________________  ____________________________
House Staff Physician's Signature and Date  Program Director's Signature and Date

__________________________
University Hospital System Official and Date

DISTRIBUTION:  UHS Physician Affairs Office
UT House Staff Coordinator
UH or VA Secretary
House Staff Member
Duty Hours
### UTHSCSA Graduate Medical Education Policies

<table>
<thead>
<tr>
<th>Section 2</th>
<th>General Policies &amp; Procedures</th>
<th>Effective:</th>
<th>April 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy 2.7</td>
<td>Clinical and Educational Work Hours (Resident Duty Hours)</td>
<td>Revised:</td>
<td>November 2006 June 2011, August 2014, September 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Responsibility:</td>
<td>Designated Institutional Official</td>
</tr>
</tbody>
</table>

## Clinical and Educational Work Hours

### Purpose
It is the policy of the UTHSCSA Graduate Medical Education Committee to follow requirements established by the ACGME regarding clinical and educational work hours for residents and fellows in accredited training programs. Specific details can be found on the ACGME website, www.acgme.org and are subject to change without notice.

### Definitions
Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, time engaged in transitions of care, assigned research activities which are part of the program’s required curriculum, and administrative duties related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. If attendance at an off-site conference is required by the program (e.g., a resident is presenting a paper or poster), those hours (but not travel time or non-conference hours) should be included as clinical and educational hours. In addition, hours spent on activities that are required in the accreditation requirements, such as membership on hospital committees, or that are accepted practice in programs, such as residents’/fellows’ participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours.

Types of work from home (either during home call or during “off time”) that must be counted include using an electronic medical record and taking patient care related telephone calls. While on home call, time spent in the hospital counts towards the 80 hour limit, but does not trigger the start of a new duty hours period.

Reading done in preparation for the following day’s cases, studying, and research done from home do not count towards the 80 hours.

**Internal Moonlighting:** Clinical and administrative activities performed within the residency program and/or the sponsoring institution or the non-hospital sponsor’s primary clinical site(s) which are voluntary and NOT required, and for which additional compensation is given. This time must be counted toward the 80-hour weekly limit on duty hours.
Policy

Each program must have written policies and procedures consistent with the Institutional and Program Requirements for clinical and educational work hours and the working environment. These policies must be distributed to the residents and the faculty. All residency programs must monitor resident duty hours, on an ongoing basis, using New Innovations. The GMEC will review program data. All programs must monitor residents for evidence of stress and fatigue related to service obligations and duty hours related to scheduled workload and moonlighting, educate faculty in monitoring residents, and develop backup plans for affected residents. When necessary for safe travel, a taxi voucher is available to fatigued residents/fellows.

Duty Hour policies:

1. Duty hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all clinical and educational work hours and all internal and external moonlighting hours.

2. Residents must be scheduled for a minimum of one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call (including at home call). One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities (including home call).

3. Residents should have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one day off in seven requirements. In addition, an abbreviated rest period shorter than eight hours creates an obligation for the program director and faculty to monitor the residents/fellows for signs of excessive fatigue.

4. Residents must have at least 14 hours free of duty after 24 hours of in-house call.

5. In-house call must occur no more frequently than every third night, averaged over a four-week period.

6. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. Up to four additional hours may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education, such as assigned conferences. Additional patient care responsibilities must not be assigned to a resident during the four hour transition/resident education period, such as the care of new patients in any patient care setting, assignment to any outpatient clinic including continuity clinics, or assignment to participate in any new procedure, such as an elective scheduled surgery.
7. In rare circumstances, after handing of all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
- To continue to provide care to a single severely ill or unstable patient;
- Humanistic attention to the needs of a patient or family; or,
- To attend unique educational events.

8. These additional hours of care or education will be counted toward the 80-hour weekly limit. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident’s fitness for work nor compromise patient safety. Time spent by residents moonlighting must be counted toward all duty hours rules. PGY-1 residents are not permitted to moonlight.

9. Night float must occur within the context of the 80-hour and one day off in seven requirements. The maximum number of consecutive weeks of night float and maximum number of months of night float per year may be further specified by a program’s Review Committee.

10. Residents must not be scheduled for in-house call more frequently than every 3rd night (when averaged over a 4-week period).

11. Time spent on patient care activities by residents on at-home call, as described in “Definitions” above, must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient care must be included in the 80-hour maximum weekly limit.

12. When an individual RC maintains a more restricted requirement, the RC requirement will supersede the requirements listed above.

**Extension of Duty Hours by 10% (to 88 hours per week)**

The GMEC will not entertain requests for waivers to extend duty hours to 88 hours per week.

**Duty Hours reporting requirements**

All UTHSCSA GME programs must document compliance with ACGME clinical and educational work hour standards via logging through New Innovations. The GME Office monitors logging compliance and adjudicates logged violations. Summaries of logging compliance and violations are reported through the Compliance and Accreditation Standing Committee to the GMEC.
ACGME

Common Program Requirements

Section VI

with Background and Intent

ACGME approved major revision of Section VI: February, 2017; effective: July 1, 2017
Common Program Requirements

Note: The term “resident” in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms “resident” and “fellow” will be used respectively.

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable. The Background and Intent text in the boxes below has been developed to provide greater detail regarding the intention behind specific requirements, as well as guidance on how to implement the requirements in a way that supports excellence in residency education.

Background and Intent: In developing the revised requirements, the Common Program Requirements Phase 1 Task Force considered all available information, including relevant literature, written comments received from the graduate medical education community and the public, and testimony provided during the ACGME Congress on the Resident Learning and Working Environment. Deliberations of the Task Force were guided by the need to develop requirements that: (1) emphasize that graduate medical education programs are designed to provide professional education rather than vocational training; (2) are based on the best available evidence; and (3) support the philosophy outlined below.

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- **Excellence in the safety and quality of care rendered to patients by residents today**
- **Excellence in the safety and quality of care rendered to patients by today’s residents in their future practice**
- **Excellence in professionalism through faculty modeling of:**
  - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
  - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- **Commitment to the well-being of the students, residents, faculty members, and all members of the health care team**

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program’s accreditation.
status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and resident and faculty member well-being. The requirements are intended to support programs and residents as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and residents. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to provide safe, high quality care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)
VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

**Background and Intent:** Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

**VI.A.1.a).(3)** Patient Safety Events

*Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.*

**VI.A.1.a).(3).(a)** Residents, fellows, faculty members, and other clinical staff members must:

**VI.A.1.a).(3).(a).(i)** know their responsibilities in reporting patient safety events at the clinical site; (Core)

**VI.A.1.a).(3).(a).(ii)** know how to report patient safety events, including near misses, at the clinical site; and, (Core)

**VI.A.1.a).(3).(a).(iii)** be provided with summary information of their institution’s patient safety reports. (Core)

**VI.A.1.a).(3).(b)** Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

**VI.A.1.a).(4)** Resident Education and Experience in Disclosure of Adverse Events

*Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an*
important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a).(4).(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

VI.A.1.b).(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1.b).(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) Residents must have the opportunity to participate in interprofessional quality improvement activities. (Core)

VI.A.1.b).(3).(a).(i) This should include activities aimed at reducing health care disparities. (Detail)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility
and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)

VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

[The Review Committee may specify which activities require different levels of supervision.]

VI.A.2.c) Levels of Supervision

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the
following classification of supervision: \(\text{(Core)}\)

VI.A.2.c).(1) Direct Supervision – the supervising physician is physically present with the resident and patient. \(\text{(Core)}\)

VI.A.2.c).(2) Indirect Supervision:

VI.A.2.c).(2).(a) with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. \(\text{(Core)}\)

VI.A.2.c).(2).(b) with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. \(\text{(Core)}\)

VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. \(\text{(Core)}\)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. \(\text{(Core)}\)

VI.A.2.d).(1) The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones. \(\text{(Core)}\)

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. \(\text{(Core)}\)

VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. \(\text{(Detail)}\)

VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). \(\text{(Core)}\)

VI.A.2.e).(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. \(\text{(Outcome)}\)
Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

VI.A.2.e),(1),(a) Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.] (Core)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core)

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

VI.B.2.c) ensure manageable patient care responsibilities. (Core)

[As further specified by the Review Committee]

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty.
specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.

VI.B.4.c) assurance of their fitness for work, including:

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, (Outcome)

VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider. (Outcome)

VI.B.6. Programs must provide a professional, respectful, and civil environment
that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.  

VI.C.  

Well-Being

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians’ ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME’s ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

VI.C.1.  

This responsibility must include:

VI.C.1.a)  

efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships;  

VI.C.1.b)  

attention to scheduling, work intensity, and work compression that impacts resident well-being;  

VI.C.1.c)  

evaluating workplace safety data and addressing the safety of residents and faculty members;  

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.
VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one’s own health, including adequate rest, healthy diet, and regular exercise.

VI.C.1.d).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

Background and Intent: The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. Materials and more information are available on the Physician Well-being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's
impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, (Core)

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes
and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

VI.D.2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)

[Optimal clinical workload may be further specified by each Review Committee.]

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

[Each Review Committee will define the elements that must be present in each specialty.]
VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

Background and Intent: In the new requirements, the terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These changes have been made in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that residents’ duty to “clock out” on time superseded their duty to their patients.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.
Scheduling
While the ACGME acknowledges that, on rare occasions, a resident may work in excess of 80 hours in a given week, all programs and residents utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule residents to work 80 hours per week and still permit residents to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that residents are scheduled to work fewer than 80 hours per week, which would allow residents to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight
With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for residents to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home
While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day’s cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident’s supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the
program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

**PGY-1 and PGY-2 Residents**

PGY-1 and PGY-2 residents may not have the experience to make decisions about when it is appropriate to utilize flexibility or may feel pressured to use it when unnecessary. Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that a resident's assigned direct patient load is manageable, that residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

**VI.F.2. Mandatory Time Free of Clinical Work and Education**

**VI.F.2.a)** The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

**VI.F.2.b)** Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

**VI.F.2.b),(1)** There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

Background and Intent: While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

**VI.F.2.c)** Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

**VI.F.2.d)** Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)
Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

Background and Intent: The Task Force examined the question of "consecutive time on task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams; and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a "shift" mentality in disciplines where overnight availability to patients is essential in delivery of care.

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-
hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.C. of these requirements.

VI.F.3.a)(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a)(1).(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

Background and Intent: The additional time referenced in VI.F.3.a)(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a)(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a)(2) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a)(3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

VI.F.4.c)(1) In preparing a request for an exception, the program
director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures. 

VI.F.4.c),(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution’s GMEC and DIO. 

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident’s fitness for work nor compromise patient safety.

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.

VI.F.5.c) PGY-1 residents are not permitted to moonlight.

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).
VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

Background and Intent: This requirement has been modified to specify that clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

***

*Core Requirements*: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

*Detail Requirements*: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

*Outcome Requirements*: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.
Resident Files
&
Records Retention
Recommended Documents for Training File – Residents/Fellows

J. Shomette 5/11/16

1. Application Documents
   a. ERAS/Universal Application/Program Application/etc.
      i. Medical School Dean’s Letter
      ii. Medical School Transcripts
      iii. USMLE/COMLEX Score Reports
      iv. Letters of Recommendation
   b. Curriculum Vitae
   c. Security/Background Check Clearance
   d. Notice of Voluntary Disclosure of SSN Form
   e. Summative Evaluation verifying previous GME training (if applicable)
   f. ECFMG Certificate (if applicable)
   g. Other documents as needed by the specific department

2. Incoming Intern/Resident/Fellow Documents
   a. Housestaff Data Sheet
   b. PIT Permit or Texas Medical License
   c. DEA and DPS Licenses (if applicable)
   d. BLS Card
   e. ACLS Card (if applicable)
   f. Internship and Residency Certificate (if applicable)
   g. IHI Certificate
   h. Other Training Certificates (as applicable)
   i. DS-2019 Form/J-1 Visa Paperwork (if applicable)

3. Contracts/Liability
   a. GME Annual Contract
   b. Liability Certificate

4. Scholarly Activity Documentation
   a. QI/PS Projects
   b. Presentations
   c. Posters
   d. Publications
   e. RCA Attendance
   f. Awards received

5. In-Training Exam Reports
6. Case/Procedure Logs
7. Conference Attendance Reports
8. 360 Degree Evaluation Summary Reports
9. Semi-Annual Evaluations with Milestones Summaries
   a. Documentation of any Disciplinary actions or status changes
10. Final Summative Evaluation and Copy of Training Certificate
11. Miscellaneous Correspondence
    a. Loan Forbearance or Deferments Forms (if applicable)
    b. Moonlighting Forms (if applicable)
    c. Vouchers
    d. Other Program Correspondence
Graduate Medical Education Records

Accreditation:

<table>
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<th>Record Series</th>
<th>Agency</th>
<th>Item #</th>
<th>Records Series Title &amp; Description</th>
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<tr>
<td>Administrative Records – General</td>
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<tr>
<td>1:1 489 DE Accreditation Records – Residency Programs. Includes correspondence to and from accrediting agency, Program Information Form (PIF) for each site visit, program requirements by year, internal reviews by GMEC (Graduate Medical Education Committee) and correspondence by GMEC regarding internal reviews, action plans developed to correct citations, correspondence with GMEC regarding action plans, residents’ evaluations of rotations, and minutes of annual review of program effectiveness.</td>
<td>PM C</td>
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Remarks: The Accreditation Council for Graduate Medical Education (ACGME) maintains a permanent list of citations for each program and carefully reviews programs in that area at each accreditation.

Applications:

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<th>Record Series</th>
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<td>Personnel Records - Employee</td>
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<tr>
<td>3:1 408 DE Residency &amp; Fellowship Applicants Information. Includes, but is not limited to, AAMC Electronic Residency Application Service (ERAS) documents including common application form, photographs, letters of recommendation, USMLE certified transcript scores, Dean’s letter, graduate transcripts, personal statements, ECFMG documents for foreign medical graduates, sanction checks, acknowledgement forms, ranking documentation, rank list to the National Resident Matching Program (NRMP), evaluations of candidates.</td>
<td>AC+2 C</td>
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Remarks: AC = end of academic year in which application is made. Records for residencies are downloaded from ERAS and usually kept electronically. 29 CFR 1602.49(a) requires 2 year retention of evaluations.

Personnel records:

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<tr>
<td>3:1 527 HR, DE Individual Personnel File - Residents/Fellows (selected) - American Medical Graduates. A comprehensive record of all personnel actions affecting residents and fellows. May also include application materials, licenses, certifications, training certificates, training permits, evaluations and performance appraisals, disciplinary records, boards records, clinical experiences, leave records, correspondence re: licensure or boards, anything of value in responding to requests for credentialing or verification.</td>
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Remarks: AC = End of training or until any dispute involving the resident has been resolved, whichever occurs later. All documents should be kept for 5 years after separation from UTHSCSA. Documents needed in verification or credentialing
(such as but not limited to evaluations /procedure logs) should be kept permanently. SEE #681 under Medical/Dental - Patient Records for Resident Physician Evaluations/Procedure Logs – Final Summative. SEE ALSO 3.1 #699 for records for international medical graduates. NOTE: All records are confidential unless permission is given by trainee. Human Resources only keeps records for Residents/ Fellows paid by UTHSCSA. SEE 3.1 #699 for foreign residents.

### Category:
**Personnel Records - Employee**

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<td>3.1</td>
<td>699</td>
<td>HR, DE</td>
<td>Individual Personnel File - Residents/Fellows (selected) - International Medical Graduates (IMGs). A comprehensive record of all personnel actions affecting residents and fellows. May also include application materials, licenses, certifications, training certificates, training permits, evaluations and performance appraisals, disciplinary records, boards records, clinical experiences, leave records, correspondence re: licensure or boards, anything of value in responding to requests for credentialing or verification.</td>
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**Remarks:** AC = End of training or until any dispute involving the resident has been resolved, whichever occurs later. All documents should be kept for 10 years after separation from UTHSCSA. Documents needed in verification or credentialing (such as but not limited to evaluations /procedure logs) should be kept permanently. SEE #681 under Medical/Dental - Patient Records for Resident Physician Evaluations/Procedure Logs – Final Summative. NOTE: All records are confidential unless permission is given by trainee. Human Resources only keeps records for Residents/ Fellows paid by UTHSCSA.

### Resident evaluations:

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<tr>
<td>8.1</td>
<td>682</td>
<td>DE</td>
<td>Resident Physician Evaluations/Procedure Logs - Formative. Created during the periods of training. Evaluations are completed by attending physicians, peer physicians, supervising physicians, residents, or medical students. Includes evaluative comments regarding clinical knowledge, skills, interpersonal relationships, and personal/professional characteristics.</td>
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**Remarks:** AC = End of training. Records are confidential unless permission is given by trainee. GME Policy 2.1.19.

### Category:
**Medical/Dental - Patient Records**

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<th>Record Series</th>
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<tr>
<td>8.1</td>
<td>681</td>
<td>DE</td>
<td>Resident Physician Evaluations/Procedure Logs – Final Summative. The final summative evaluation is prepared by the program director at the end of the training program, and addresses the resident's performance during the final period of education and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently in that specialty. Evaluation is based on previous evaluations completed by attending physicians, peer physicians, supervising physicians, residents, or medical students. Includes evaluative comments regarding clinical knowledge, skills, interpersonal relationships, and personal/professional characteristics. Records also include procedure logs to assure accreditation process for future hospital privileges.</td>
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**Remarks:** Records are confidential unless permission is given by trainee. May be filed with Individual personnel File for Residents/Fellows (SEE: 3.1 # 527). GME Policy 2.1.19.
Other Administrative records:

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**Category:** Administrative Records - General

| 1.1 | 680 | DE | Residency Programs Curriculum Records. Includes but is not limited to schedules of conferences, curriculum used in residency programs, attendance sheets for conferences and special programs. | AC+1             | O             |               |              |

**Remarks:** AC = Program length (i.e. AC = 4 years for a 4 year training program).

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**Category:** Student Records

| 9.1 | 385 | DN, DE | Continuing Medical Education (CME), Continuing Dental Education (CDE), Continuing Nursing Education (CNE) Class Records. | 6                | C             |               |              |

**Remarks:** Departments should keep records on attendance at continuing education courses as Student Services only records grades and attendance for officially registered students of the UTHSCSA. CME, CNE Attendance records are kept on computer indefinitely; paper files for 6 years. The Accreditation Council for Continuing Medical Education (ACCME) requires records be kept on file for a minimum of 6 years.

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**Category:** Fiscal Records - Other Fiscal

| 4.7 | 529 | DN, DE | Continuing Medical Education (CME), Continuing Dental Education (CDE), Continuing Nursing Education (CNE) Activity Fiscal Records. | 6                | C             |               |              |

**Remarks:** CME activity fiscal records are kept on computer indefinitely; paper files for 6 years. The Accreditation Council for Continuing Medical Education (ACCME) requires records be kept on file for a minimum of 6 years.

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**Category:** Administrative Records - General

| 1.1 | 530 | DN, DE | Continuing Medical Education (CME), Continuing Dental Education (CDE), Continuing Nursing Education (CNE) Records Other than Fiscal or Attendance. | 6                | C             |               |              |

**Remarks:** CME activities related documents (not fiscal or attendance). The Accreditation Council for Continuing Medical Education (ACCME) requires records be kept on file for a minimum of 6 years. SEE 4.7 # 529 for fiscal; SEE 9.1 # 385 for attendance.
### Personnel Records - Personnel Administration

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<td>109</td>
<td>Work schedules/block schedules/assignments. Work, duty, shift, crew, or case schedules, rosters, or assignments.</td>
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**Remarks:** CAUTION: Texas State Retention Schedule requires at least 1 year retention. Paper schedules and electronic schedules for residents and fellows should be retained in the event of a Medicare audit for 10 years after FE.

### Medical/Dental - Patient Records

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<th>Record Series</th>
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<th>Records Series Title &amp; Description</th>
<th>Retention Period</th>
<th>Security Code</th>
<th>Archival Code</th>
<th>Vital Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>DE</td>
<td></td>
<td>687</td>
<td>Morbidity &amp; Mortality (M&amp;M) Records for Residency Programs. This record series includes peer-reviews of clinical operations.</td>
<td>AV</td>
<td>C</td>
<td></td>
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</tbody>
</table>

**Remarks:** A 3 year retention period is recommended by Clinical Affairs and GME (Graduate Medical Education).

### Student Records

<table>
<thead>
<tr>
<th>Record Series</th>
<th>Agency Area</th>
<th>Dept.</th>
<th>Item #</th>
<th>Records Series Title &amp; Description</th>
<th>Retention Period</th>
<th>Security Code</th>
<th>Archival Code</th>
<th>Vital Record</th>
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<tbody>
<tr>
<td>9.1</td>
<td>DE</td>
<td></td>
<td>364</td>
<td>Postdoctoral Training Records.</td>
<td>10</td>
<td>C</td>
<td></td>
<td></td>
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</tbody>
</table>

**Remarks:** Departments should keep track of postdoctoral training students as Student Services only records grades and attendance for officially registered students of the UTHSCSA. Records may be filed in personnel file for Residents/Fellows and kept longer than 10 years for certification purposes.
Program Letters of Agreement
**Program Letters of Agreement (PLAs)**

As of February 10, 2016

### General Information

When should PLAs be renewed:
- Must be renewed every three years (stricter than the ACGME requirements).
- Whenever there are **significant** changes to any facts (e.g., signers, goals & objectives, PD, Site Director, etc.).

1. Be sure you are using the most current template ([http://www.uthscsa.edu/gme/formstemplates.asp](http://www.uthscsa.edu/gme/formstemplates.asp)).
2. All PLAs must be on letterhead.
3. Signature blocks for the major institutions are posted on the GME website.
4. Provide two copies of UHS and VA PLAs.
5. Goals and objectives (DO NOT INCORPORATE INTO THE PLAs):
   a. Provide the link where they can be accessed, or
   b. Attach a copy to the PLA prior to submitting for signature
6. Needle-stick Policies
   a. The needle-stick policy link for UHS, VA, CHRISTUS, Methodist, and SAUSHEC is in the PLA Template: [http://www.uthscsa.edu/gme/residentsfellows.asp](http://www.uthscsa.edu/gme/residentsfellows.asp).
   b. If the PLA is for a site other than UHS, VA, CHRISTUS, Methodist, or SAUSHEC, you must provide a statement, in paragraph IV.e. of the PLA, either describing the policy or noting that it is attached to the PLA.
7. Process for submitting the PLA for signature:
   a. Prior to obtaining signatures, a draft of the PLA may be emailed to the GME Accreditation Manager for review.
      i. If no corrections are required and emailed PLA is on letterhead, the GME Manager will sign.
      ii. If corrections are needed, the PLA will be returned to the program for correction.
   b. After the GME manager signs the document, it will be returned to the program to obtain all the remaining signatures except the DIO’s. EXCEPTION: UHS PLAs must be signed by Dr. Bready prior to obtaining Dr. Alsip’s and Mr. Hernandez’s signatures.
   c. After all signatures are obtained, the PLA should be returned to the Accreditation Manager to obtain the DIO’s signature.

### ACGME Accredited Programs Signatures

<table>
<thead>
<tr>
<th>UHS</th>
<th>CHRISTUS Santa Rosa</th>
<th>VA Hospital</th>
<th>Methodist Hospital</th>
<th>SAUSHEC</th>
</tr>
</thead>
</table>

### Resident Rotations at a Program within the Sponsoring Institution

- Generally, PLAs are not required by ACGME, but are strongly encouraged as a means to clearly communicate conditions of the rotations. Examples:
  - MARC and CTRC
  - On-campus clinics, such as those in psychiatry and ophthalmology

### Resident Visiting from Another Institution

- It is the responsibility of the program **sending** the resident, not the program **accepting** the resident to provide a PLA.
- It is the responsibility of the accepting UT PD to decide that the training of your residents will not be impacted by a visiting resident. If the PD signs the PLA, that is an indication that your residents’ training is not impacted by the visitor.
- The DIO does not need to sign unless required by the visiting resident’s institution.

### Non-ACGME Accredited Programs

- Are there requirements for your fellowship that require a PLA? (You need to provide these requirements for DAR as well.)
- If your program wants to have a PLA in place, you may use the GME template and modify it to fit your program’s needs.

*As defined by program requirements – see www.acgme.org

X:\documents\PLA Process\2017-02 PLA Process Tableformat.docx
Program Letter of Agreement
between
University of Texas School of Medicine at San Antonio
Graduate Medical Education
Name of Program and Participating Site

This document serves as an Agreement between University of Texas School of Medicine at San Antonio (University) Name of Program and Participating Site involved in Graduate Medical Education of medical residents/fellows. This Agreement is effective from Date and will remain in effect for three years, or until updated, changed, or terminated by the Name of Program and Participating Site. Any modifications or changes to this agreement must be in writing and signed by all parties. This agreement may be canceled by either party upon written notice to the other party 90 days prior to termination.

I. Faculty Responsible for Education and Supervision
   a. At University: Program Director
   b. At Participating Site and Address: Local Director/Program Director
   c. (If other faculty are involved, list by name or group)
   d. The above listed individuals are responsible for the education, supervision, and evaluation of the residents/fellows while rotating at Participating Site. If this responsibility is assumed by another individual, the program director will receive prior notification in writing for approval of the successor.

II. Faculty Teaching, Supervision, and Evaluation Responsibilities (CPR I.A.2.)
   a. The faculty at Participating Site must provide appropriate supervision of residents/fellows in patient care activities and maintain a learning environment conducive to educating the residents/fellows in the ACGME competency areas. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment. Residents are expected to complete confidential faculty evaluations upon completion of the assignment.
   b. It is understood that the University, as the institutional sponsor of the training program, continues to have responsibility for the quality of this educational experience and must retain authority over the residents' activities. The University has the right to conduct an on site review of the training policies and practices relevant to this training. The University Department of (insert department name) will support faculty appointments for Participating Site faculty in accordance with the policies and procedures of the University.
III. Content and Duration of the Education (CPR IV.)

a. The content of the educational experiences has been developed according to ACGME Residency/Fellowship Program Requirements.

b. The educational purpose of this rotation is to (insert statement - why this rotation is important). The goals and objectives for this rotation are:
   - Attached to PLA.
   - Available at the following link: ________________________________________________________________________

c. Residents will rotate in insert duration e.g. one month, 6 weeks, etc. blocks, as scheduled by the program director and on site coordinator. Prior notice, when possible, will be made for any changes in these rotations. (you may insert more specifics in terms of numbers of residents and blocks if appropriate)

IV. Policies and Procedures that Govern Resident Education

a. The Residents/Fellows will be under the general direction of the University’s Graduate Medical Education Committee’s GME policies (at www.uthscsa.edu/gme), the University Health System House Staff Policies and Procedures Manual, which is incorporated by reference, and the site-specific policies for the Participating Site.

b. The source of funds for the resident’s salary will be specified in his/her contract with the University Health System. For residents salaried by the South Texas Veterans Health Care System (STVHCS), Audie L. Murphy Division, affiliated community hospitals or the University Health System (UHS), the University Health System serves as paymaster for the purpose of disbursement of residents’ salary and benefits according to a uniform pay scale. The University of Texas will provide professional liability indemnity coverage under a self-insurance plan for its salaried residents rendering services under this agreement. Residents working at the STVHCS are immune from individual liability. Protection is provided by the Federal Government under the Federal Tort Claims Act. For general liability, UHS and its employees are governed by the applicable provisions of the Tort Claims Act, as provided in the Texas Civil Practice and Remedies Code.

c. In event of injury, UHS and UTHSCSA maintain workman's compensation coverage for all employees, including residents. In the event of a needle-stick or other exposure to potential blood-borne pathogens, the resident will have access to medical evaluation and post-exposure prophylaxis through the following mechanism and can be access at the GME website:
   http://www.uthscsa.edu/gme/residentsfellows.asp

d. Other benefits and rights of the resident are addressed in the University Health System House Staff Policies and Procedures Manual, which is incorporated by reference, and the UTHSCSA GME Policies and Procedures available at www.uthscsa.edu/gme.

e. This training will be in compliance with the requirements for duty hours and resident supervision requirements of the Accreditation Council for Graduate Medical Education.

f. The Local Director shall have the right to require the University to remove resident physicians from this rotation with or without cause.
g. Residents shall cooperate in the prompt preparation of documentation of all examinations, procedures and other professional services performed by them at the training site in accordance with local regulations and bylaws. The ownership and right of control of all reports, records, and supporting documents prepared in connection with this belong to the Participating Site.

**University of Texas School of Medicine**

Robert J. Nolan, Jr., MD  
Associate Dean for Graduate Medical Education / Interim Designated Institutional Official  
University of Texas School of Medicine at San Antonio

**Participating Site**

Insert name  
CEO, Affiliated Site

(Name of Department Chair or Designee)  
Department Chair (or equivalent title)  
Department of (Department)

Dr. (Training Site Dept Chair)  
Dept Chairman (or equivalent title)

(Program Director)  
Program Director, (Name of program)

Dr. (insert name)  
Site Program Coordinator

Dr. (Subspecialty Program Director)  
>Title

J. Travis Pederson  
GME Manager, Finance and Administration
Annual Program Evaluation (APE)
### Section 3 Evaluation and Assessment Processes

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Responsibility:</td>
<td>Designated Institutional Official</td>
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</table>

### GMEC Oversight of ACGME-Accredited Programs

**Purpose**

It is the responsibility of the Graduate Medical Education Committee (GMEC) to oversee the quality of Graduate Medical Education and the learning and working environment for ACGME-accredited programs. The GMEC assures the quality of educational experiences in each program by examining quantifiable metrics and educational outcomes. This oversight process is designed to facilitate a culture of continuous quality improvement.

**Policy**

Oversight of ACGME-accredited programs will consist of Accreditation Data System Update Review, Annual Program Evaluation, Periodic Program Review, Special Program Review, Pre Self-Study Review, Self-Study Summary Review and Mock Site Visit:

- **Accreditation Data System (ADS) Update Review**
  
  GME Faculty will review all ADS updates submissions. Four weeks prior to the submission deadline, the proposed update should be ready for review. Program leadership will receive feedback regarding their proposed submission at least two weeks prior to the submission deadline.

- **Annual Program Evaluation (APE)** (CPR V.C.2.) see GME Policy 3.5
  
  - APEs will be conducted annually by the program and reviewed by the GMEC Compliance & Accreditation Standing Committee.
  

- **Periodic Program Review (PPR)**
  
  - PPR will be conducted approximately midway between the last Site Visit and the scheduled Pre Self-Study Review by a PPR panel and reviewed by the GMEC Compliance & Accreditation Standing Committee.
  
  - See Addendum B, Periodic Program Review Protocol.
• **Special Program Review (SPR)** (IR I.C.4.e.)
  - SPRs may be triggered by one or more of the following:
    - Negative communication from the ACGME
    - Resident complaint to ACGME
    - Duty hours non-compliance
    - Negative ACGME Faculty Survey trends
    - Negative ACGME Resident Survey trends
    - Significant concerns from APE
    - Match issues
    - Resident attrition
    - Scholarly activity deficiencies
    - Negative Milestones trends
    - Other at the discretion of the DIO
  - An SPR may be focused on specific areas or concern or may be broader in scope.
  - The SPR will be conducted by an SPR panel and reviewed by the GMEC Compliance and Accreditation Standing Committee.
  - See Addendum C, **Special Program Review Protocol**.

• **Pre Self-Study Review (PSSR)**
  - The PSSR will be conducted approximately 2 years prior to the scheduled Self-Study by GME Faculty and reviewed by the GMEC Compliance and Accreditation Standing Committee.
  - See Addendum D, **Pre Self-Study Review Protocol**.

• **Self-Study (SS) Summary Review**
  - The Self-Study (SS) Summary will be reviewed by GME Faculty prior to submission to the ACGME.
  - See Addendum E, **Self-Study Summary Review Protocol**.

• **Mock Site Visit (MSV)**
  - The MSV format will be developed consistent with the ACGME 10-Year Accreditation Site Visit protocol as it becomes available.
  - See Addendum F, **Mock Site Visit Protocol**.

**Consequences of chronic and persistent program deficiencies** - This oversight process is designed to facilitate a culture of continuous quality improvement. In the event that this process reveals a significant lack of substantial compliance with ACGME and other requirements, a program may be subject to more intense levels of
Consequences of failure to maintain substantial compliance include the following:

- Repeat Special Program Review – the GMEC may recommend a repeat SPR to further clarify areas of deficiency; this step is not mandatory
- Internal Probation – the GMEC may recommend that a program be placed on the status of Internal Probation. Consequences of Internal Probation may include:
  - More frequent and intensive reporting on issues of concern in the SPR
  - Recommendations for replacement of key faculty/leadership within the program
  - Other interventions as appropriate
  - Recommendation for Voluntary Withdrawal of Accreditation by the appropriate ACGME Review Committee

References

ACGME Institutional Requirements Effective 7/1/15, I.C.4.e.
Addendum A

Annual Program Evaluation (APE) Protocol

Effective January 1, 2017

According to the ACGME Common Program Requirements, section V.C.2., the program, through the Program Evaluation Committee (PEC), must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written Annual Program Evaluation (APE).

In addition, the program must monitor and track each of the following areas: resident performance; faculty development; graduate performance, including performance of program graduates on the certification examination; program quality; program wellness initiatives; and policies, protocols and procedures.

The PEC must prepare minutes and a written plan of action, using the required Annual Program Evaluation Minutes (APE) and Action Plan template to document initiatives to improve performance as well as delineate how they will be measured and monitored. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

The APE Process (See Sample Timeline in Appendix A.1.)

Programs will be assigned a date by which the program component APE process must be complete. This specific assigned date will recur yearly to facilitate long-term planning. The multi-step process is outlined below:

1. The program will receive a reminder notification 90 days in advance from the GME Office of the due date for completion of the program component of the APE process.*
2. The program completes the APE form in New Innovations.
3. The PEC conducts the APE Meeting.
4. The program submits the Annual Program Evaluation Minutes (APE) and Action Plan (see Appendix A.2.) through New Innovations by the assigned due date.
5. An Annual Program Evaluation Report (see Appendix A.3.) is generated and reviewed by the GMEC Compliance & Accreditation Standing Committee. The standing committee will either:
   a. Accept the report and action plan
   b. Ask for clarification/additional documentation
   c. Determine the need for a Special Program Review (SPR)
6. The Annual Program Evaluation Report is presented to the GME Executive Committee and to the GMEC.
7. Program leaders meet with GME Faculty for debrief (core programs, only).
APE Materials

At a minimum, the following materials (documenting resident performance, faculty development, graduate performance and program quality) should be reviewed as part of the program component of the APE process:

- Completed New Innovations Annual Program Evaluation form
- Most recent ACGME Letter of Notification
- Most recent ACGME Resident and Faculty Survey summaries
- Core faculty development activities
- Previous Annual Program Evaluation (APE) Minutes and Action Plans
- Milestone patterns/trends suggesting the need for faculty development or curricular revision
- Resident/Fellow quality improvement activities
- Resident/Fellow scholarly activities
- Faculty scholarly activities
- Ongoing “wellness” activities

Program APE Meeting

The program APE meeting should be conducted by the PEC within 90 days of the due date for completion of the program component of the APE process. The format for the meeting must be a SWOT (strengths, weaknesses, opportunities and threats) analysis of the program based on the materials provided and the participants’ knowledge of the program’s activities and processes.

APE Action Plan

An action plan must be created from the results of the SWOT analysis and documented using the Annual Program Evaluation (APE) Minutes and Action Plan Template. The action plan must be reviewed and approved by the teaching faculty and documented in meeting minutes of a faculty meeting. The action plan should be distributed to all residents/fellows.

GMEC Oversight

The GMEC Compliance & Accreditation Standing Committee will review the Annual Program Evaluation Report at its monthly meeting as designated by the GME Program Oversight Calendar and either:

a. Accept as submitted  
b. Ask for clarification/additional documentation  
c. Determine the need for a Special Program Review (SPR)

The Annual Program Evaluation Report will be presented to the GME Executive Committee and to the GMEC.
Appendix A.1.

Sample Timeline for APE Process

Program with an “April” assignment on the GMEC Program Oversight Calendar

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>1. The program will receive a reminder notification of the due date for completion of the program component of the APE process.</td>
</tr>
<tr>
<td></td>
<td>2. The program completes the APE form in New Innovations.</td>
</tr>
<tr>
<td></td>
<td>3. The PEC conducts the APE.</td>
</tr>
<tr>
<td>April 1</td>
<td>4. The program submits the Annual Program Evaluation (APE) Minutes and Action Plan (through New Innovations) by the assigned due date.</td>
</tr>
<tr>
<td>4th Monday in April</td>
<td>5. An Annual Program Evaluation Report is created and reviewed by the GMEC Compliance &amp; Accreditation Standing Committee.</td>
</tr>
<tr>
<td>2nd Tuesday in May</td>
<td>6. The Annual Program Evaluation Report is presented to the GME Executive Committee and to the GMEC.</td>
</tr>
<tr>
<td></td>
<td>7. If necessary, Program leaders meet with GME Faculty for debrief (core programs, only)</td>
</tr>
</tbody>
</table>
Appendix A.2.

Annual Program Evaluation (APE)

Minutes & Action Plan

Program

Date

Date of the APE meeting:

Date Minutes & Action Plan were reviewed and Approved by teaching faculty:

Please attach the minutes of the meeting where the Minutes & Action Plan were reviewed and approved.

Academic Year reviewed:

Faculty Members of the PEC in attendance:

Resident/Fellow Members of the PEC in attendance:

Other Members of the PEC in attendance:

**Question 1: Program description**

Provide a brief description of your residency/fellowship program, as you would to an applicant or a prospective faculty member. Discuss any notable information about this program. (Maximum 250 words)

**Question 2: Program aims**

Based on information gathered and discussed during the APE, what are the program’s aims? (Maximum 150 words)

**Question 3: Program activities to advance the aims**

All proceedings and records of the Graduate Medical Education Committee are confidential and all professional review actions and communications made to the Graduate Medical Education Committee are privileged under Texas and federal law. TEX. OCC. CODE ANN. CHPS.151 & 160; TEX HEALTH AND SAFETY CODE §161.032; and 42 U.S.C. 11101 et seq.
Describe current activities that have been or are being initiated to promote or further these aims. (Maximum 250 words)

Areas reviewed:

☐ Resident performance
   Supporting documents:

☐ Faculty development
   Supporting documents:

☐ Graduate performance
   Supporting documents:

☐ Program quality
   Supporting documents:

☐ Policies, Protocols & Procedures
   Supporting documents:

☐ Supervision, Progressive Responsibility and Transition of Care
   Supporting documents:

☐ Program Wellness Initiatives
   Supporting documents:

☐ Progress on the Action Plan from the Previous Academic Year
   Supporting documents:

All proceedings and records of the Graduate Medical Education Committee are confidential and all professional review actions and communications made to the Graduate Medical Education Committee are privileged under Texas and federal law. Tex. Occ. Code Ann. Chps. 151 & 160; Tex Health and Safety Code §161.032; and 42 U.S.C. 11101 et seq.
SWOT Analysis

Strengths

Weaknesses

Opportunities

Threats

All proceedings and records of the Graduate Medical Education Committee are confidential and all professional review actions and communications made to the Graduate Medical Education Committee are privileged under Texas and federal law. TEX. OCC. CODE ANN. CHPS.151 & 160; TEX HEALTH AND SAFETY CODE §161.032; and 42 U.S.C. 11101 et seq.
## Action Plan

<table>
<thead>
<tr>
<th>Item</th>
<th>Strategy</th>
<th>Resources</th>
<th>Timeline</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preservation Goals (Strengths)</td>
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<tr>
<td>Elimination Goals (Weaknesses)</td>
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</tr>
<tr>
<td>Achievement Goals (Opportunities)</td>
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<td></td>
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<tr>
<td>Avoidance Goals (Threats)</td>
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</tbody>
</table>
Appendix A.3.

Annual Program Evaluation
Report

Program:

Month/Year Reviewed:

Academic Year Evaluated:

Reviewers:

Date presented to the C & A Standing Committee:

Date presented to the GME Executive Committee:

Date presented to the GMEC:

☐ Ni APE Form

Areas of concern from Ni APE Form:

Comments:

☐ ACGME Resident Survey

Areas of concern from most recent ACGME Resident Survey:

☐ ACGME Faculty Survey

Areas of concern from most recent ACGME Faculty Survey:

☐ PEC APE Minutes & Action Plan

Areas of concern from the PEC APE Minutes & Action Plan:

  Resident Performance:

  Faculty Development:

  Graduate Performance:

  Program Quality:

  Policies, Protocols and Procedures:
Supervision, Progressive Responsibility and Transition of Care:

Wellness Initiatives:

Suggested modifications to APE Action Plan:

General Comments:

Summary:
Addendum B

Periodic Program Review (PPR) Protocol

Effective July 1, 2017

The revised ACGME Institutional Requirements (effective July 1, 2014) section 1.B.4. a) (GMEC Responsibilities) includes but is not limited to: oversight of the institution and ACGME-accredited programs (1.B.4. a (1)), the quality of the working environment (1.B.4.a (2)), the quality of the educational experiences (1.B.4.a (3)), and the ACGME-accredited programs’ annual evaluation and improvement activities (1.B.4.a (4)). Missing are requirements for an internal review at the mid-point of a program's accreditation cycle. But, according to the ACGME, the GMEC must implement a process for continuous improvement for all ACGME-accredited programs. The Periodic Program Review (PPR) is this process.

The PPR Process (see Sample Timeline in Appendix B.1.)

Programs will be assigned a date by which the program component APE process must be complete. This specific assigned date will recur yearly to facilitate long-term planning. The multi-step process is outlined below:

1. The program will receive a reminder notification 120 days in advance from the GME Office of the due date for completion of the program component of the APE process. The program will be contacted by the GME Office to schedule their PPR for that month.*
2. The program must update ADS.
3. The program completes the APE form in New Innovations.
4. The PEC conducts the APE.
5. The program submits the Annual Program Evaluation Minutes and Action Plan (see Appendix B.2.) through New Innovations to the GMEC Compliance and Accreditation Subcommittee by the assigned date. The program must use the Annual Program Evaluation Minutes and Action Plan template available on the GME website.
6. The PPR will be conducted and a Periodic Program Review Report (see Appendix B.3) will be generated.
7. The GMEC Compliance & Accreditation Standing Committee will review the Periodic Program Review Report and either:
   a. Accept as written
   b. Ask for clarification/additional documentation
   c. Determine the need for a Special Program Review (SPR)
8. The Periodic Program Review Report reviewed by the GMEC Compliance & Accreditation Subcommittee are presented to the GMEC.
**PPR Materials**

In addition to the materials required for the APE, the following will be required for the PPR:

- Sample competency-based goals and objectives for one assignment and for each educational level of training
- Evaluation templates (not completed evaluations):
  - Resident/fellow at the completion of each assignment
  - Evaluations demonstrating the use of multiple evaluators (e.g., faculty, peer, self)
  - Semiannual evaluation
  - Final (summative) evaluation
  - Confidential evaluations of faculty by the resident/fellow
  - Confidential evaluation of the program by faculty
  - Confidential evaluation of the program by resident/fellow
- Policies/protocols:
  - Moonlighting
  - Definition of common patient care circumstances when the supervising faculty member must be involved
  - Documentation for episodes when resident/fellows remain on duty beyond scheduled hours
- Evidence of resident/fellow participation in Quality Improvement projects
- Evidence of resident/fellow participation in Patient Safety projects
- Written description of the Program Evaluation Committee’s composition and responsibilities
- Written description of the Clinical Competence Committee’s composition and responsibilities

These materials must be uploaded into NI no later than 10 business days prior to the scheduled PPR.

**The PPR Participants and Meeting**

The PPR will be chaired and co-chaired by two Associate and/or Assistant Deans of GME who also serve on the GMEC Compliance and Accreditation Subcommittee. Panel members from other programs will include at least two additional faculty members, at least two residents, at least one program coordinator and others as deemed necessary by the panel chair. Interviewees will include the Departmental Chair, Program Director, Program Coordinator, Departmental Administrator, Quality Champion, Faculty Development Leader, Core Program Director or designee (if applicable), at least four representative core faculty, and two peer-selected residents from each level of training. If the program being reviewed is a dependent subspecialty, the Program Director for the respective core program will be interviewed with the program leadership.
Reviews will be scheduled for 8:00-noon:

8:00-9:15 am  Meeting with Chair or delegate, Program Director, Program Coordinator, Departmental Administrator, Quality Champion, Faculty Development Leader and Core Program Director or designee (if applicable)

9:15-9:30 am  Break

9:30-10:30 am  Meeting with Residents/Fellows

10:30-11:15 am  Meeting with Representative Core Faculty

If residents/fellows rotate at the VA, the site director(s) for the VA must be present.

11:15-noon  If necessary, meeting with Program Director and Program Coordinator

PPR Report

The co-chairs of the panel will compose a written report and action plan detailing the findings of the panel. The report will be submitted to the GMEC Compliance and Accreditation Standing Committee. The GMEC Compliance and Accreditation Standing Committee will review the Periodic Program Review Report. The Periodic Program Review Report will be submitted to the GME Executive Committee and to the GMEC. Progress on action plans will be accessed at the time of the next APE, or sooner if determined by the GMEC Compliance and Accreditation Standing Committee.

GMEC Monitoring of Outcomes

The GMEC Compliance and Accreditation Subcommittee will review the Periodic Program Review Report at its monthly meeting as designated by the GME Program Oversight Calendar and either:

a. Accept as submitted
b. Ask for clarification/additional documentation
c. Determine the need for a Special Program Review (SPR)

The report is presented to the GME Executive Committee and to the GMEC.
Appendix B.1

Sample Timeline for PPR Process

Program with an "April" assignment on the GMEC Oversight Calendar

<table>
<thead>
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<tr>
<td>April 1</td>
<td>5. The program submits the Annual Program Evaluation Minutes and Action Plan (through New Innovations) and other required documents by the assigned due date.</td>
</tr>
<tr>
<td>April</td>
<td>6. The PPR will be conducted and a Periodic Program Review Report will be generated.</td>
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<tr>
<td>4th Monday of April</td>
<td>7. The GMEC Compliance &amp; Accreditation Standing Committee will review the Periodic Program Review Report and Action Plan.</td>
</tr>
<tr>
<td>2nd Tuesday of May</td>
<td>8. The Periodic Program Review Report reviewed by the GMEC Compliance &amp; Accreditation Standing Committee are presented to the GME Executive Committee and the GMEC.</td>
</tr>
</tbody>
</table>
Appendix B.2.

Annual Program Evaluation (APE)

Minutes & Action Plan

Program

Date

Date of the APE meeting:

Date Minutes & Action Plan were reviewed and Approved by teaching faculty:

Please attach the minutes of the meeting where the Minutes & Action Plan were reviewed and approved.

Academic Year reviewed:

Faculty Members of the PEC in attendance:

Resident/Fellow Members of the PEC in attendance:

Other Members of the PEC in attendance:

**Question 1: Program description**

Provide a brief description of your residency/fellowship program, as you would to an applicant or a prospective faculty member. Discuss any notable information about this program. (Maximum 250 words)

**Question 2: Program aims**

Based on information gathered and discussed during the APE, what are the program’s aims? (Maximum 150 words)

**Question 3: Program activities to advance the aims**

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Describe current activities that have been or are being initiated to promote or further these aims. (Maximum 250 words)

Areas reviewed:

☐ Resident performance
Supporting documents:

☐ Faculty development
Supporting documents:

☐ Graduate performance
Supporting documents:

☐ Program quality
Supporting documents:

☐ Policies, Protocols & Procedures
Supporting documents:

☐ Supervision, Progressive Responsibility and Transition of Care
Supporting documents:

☐ Program Wellness Initiatives
Supporting documents:

☐ Progress on the Action Plan from the Previous Academic Year
Supporting documents:

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SWOT Analysis

Strengths

Weaknesses

Opportunities

Threats

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# Action Plan

<table>
<thead>
<tr>
<th>Item</th>
<th>Strategy</th>
<th>Resources</th>
<th>Timeline</th>
<th>Evaluation</th>
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<tr>
<td>Avoidance Goals (Threats)</td>
<td></td>
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</tr>
</tbody>
</table>
Appendix B.3.

Periodic Program Review Report

Program:

Date Reviewed:

Academic Year Evaluated:

Panel Members:

Interviewees:

Program Director:

Assistant Program Director:

Quality Champion:

Faculty Development Leader:

Program Coordinator:

Residents/Fellows:

Representative Core Faculty:

Core Program Director (if applicable):

Date presented to the Compliance & Accreditation Standing Committee:

Date presented to the GME Executive Committee:

Date presented to the GMEC:

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Program Leadership Meeting

☐ Document Review
   Comments:

☐ Action Plan Review
   Comments:

☐ Program Resource Review
   Comments:

Residents/Fellows Meeting

☐ ACGME Resident Survey Review
   Comments:

☐ Action Plan Review
   Comments:

☐ Procedure/Case Numbers Review
   Comments:

Core Faculty Meeting

☐ ACGME Faculty Survey Review
   Comments:

☐ Action Plan Review
   Comments:

☐ Program Resources Review
   Comments:
Addendum 3

Special Program Review (SPR) Protocol

Effective January 1, 2017

According to the ACGME Institutional, section I.B.6., the GMEC must demonstrate effective oversight of underperforming programs through a Special Review process. The Special Review process must include a protocol that establishes criteria for identifying underperformance and results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes. This protocol outlines the process for the Special Program Review (SPR).

The SPR Process (See sample timeline in Appendix C.1.)

1. The GMEC Compliance and Accreditation Standing Committee will review the Annual Program Evaluation Minutes and Action Plan and either:
   a. Accept
   b. Ask for clarification/additional documentation
   c. Recommend the need for a Special Program Review (SPR)

2. If the need for an SPR is identified, a proposal for an SPR (see Appendix C.2.) will be presented to the GMEC Executive Committee. The committee will either:
   a. Accept the proposal
   b. Modify the proposal
   c. Reject the proposal

3. If the SPR proposal is modified or accepted, the SPR will be scheduled. If the SPR proposal is rejected, oversight of the program reverts to the standard APE process.

4. The SPR will be scheduled within 45 days of the GMEC Executive Committee’s approval.

5. The SPR will be conducted and a Special Program Review Report and Action Plan (see Appendix C.3.) will be created.

6. The GMEC Compliance & Accreditation Standing Committee will review the Special Program Review Report and Action Plan and either:
   a. Accept the report
   b. Ask for clarification/additional documentation
   c. Recommend Internal Probation

7. The Special Program Review Report and Action Plan reviewed by the GMEC Compliance & Accreditation Standing Committee is presented to the GMEC Executive Committee and to the GMEC.

8. Progress on action plans will be assessed at the time of the next APE unless the program is placed on Internal Probation.

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Criteria for Identifying Underperformance

In addition to the process outlined above, other potential triggers for an SPR include but are not limited to:

- Negative communication from the ACGME
- Resident complaint to ACGME
- Duty hours non-compliance
- Negative ACGME Faculty Survey trends
- Negative ACGME Resident Survey trends
- Significant concerns from APE
- Match issues
- Resident attrition
- Scholarly activity deficiencies (either resident or faculty)
- Negative Milestones trends
- Failure to adequately address action plan items from a previous SPR
- Non-compliance with program oversight processes
- Other at the discretion of DIO

SPR Materials

Materials requested for the SPR will be determined by the GMEC Compliance and Accreditation Standing Committee and referenced in the proposal to the GMEC Executive Committee. The materials will be selected based on the deficits identified.

SPR Program Participants

Program representatives to be interviewed during the SPR will be determined based on the deficits identified.

The SPR Meeting

The SPR will be co-chaired by the chair and co-chair of the GMEC Compliance and Accreditation Standing Committee. Panel composition will be dependent upon the rationale for the SPR.

SPR Report

The co-chairs of the panel will compose a Special Program Review Report detailing the findings of the panel. The Special Program Review Report will be submitted to the GMEC Executive Committee and to the GMEC. Progress on action plans will be accessed at the time of the next APE.
GMEC Monitoring of Outcomes

GMEC monitoring of outcomes is operationalized in the GMEC Compliance and Accreditation Standing Committee with reports to the GMEC.
Appendix C.1.

Sample Timeline for SPR Process

Program with an “April” assignment on the GMEC Program Oversight Calendar

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>1. The program will receive a reminder notification of the due date for completion of the program component of the APE process.</td>
</tr>
<tr>
<td></td>
<td>2. The program must update ADs.</td>
</tr>
<tr>
<td></td>
<td>3. The program completes the APE form in New Innovations.</td>
</tr>
<tr>
<td></td>
<td>4. The PEC conducts the APE.</td>
</tr>
<tr>
<td>April</td>
<td>5. The program submits the Annual Program Evaluation Minutes and Action Plan (through New Innovations) by the assigned due date.</td>
</tr>
<tr>
<td>4th Monday in April</td>
<td>6. The GMEC Compliance and Accreditation Standing Committee will review the Annual Program Evaluation (APE) materials and Annual Program Evaluation Minutes and Action Plan and determine the need for a Special Program Review (SPR).</td>
</tr>
<tr>
<td>1st Thursday in May</td>
<td>7. If the need for an SPR is identified, a proposal for an SPR will be presented to the GMEC Executive Committee. The committee will either:</td>
</tr>
<tr>
<td></td>
<td>a. Accept the proposal</td>
</tr>
<tr>
<td></td>
<td>b. Modify the proposal</td>
</tr>
<tr>
<td></td>
<td>c. Reject the proposal</td>
</tr>
<tr>
<td>May</td>
<td>8. If the SPR proposal is modified or accepted, the SPR will be scheduled. If the SPR proposal is rejected, oversight of the program reverts to the standard APE process.</td>
</tr>
<tr>
<td>June</td>
<td>9. The SPR will be scheduled within 45 days of the GMEC Executive Committee’s approval.</td>
</tr>
<tr>
<td></td>
<td>10. The SPR will be conducted and a Special Program Review Report and Action Plan is generated.</td>
</tr>
<tr>
<td>4th Monday in July</td>
<td>11. The GMEC Compliance &amp; Accreditation Standing Committee will review the Special Program Review Report and Action Plan and either:</td>
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<tr>
<td></td>
<td>a. Accept the report</td>
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<td></td>
<td>b. Ask for clarification/additional documentation</td>
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<td>c. Recommend Internal Probation</td>
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</table>

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| 1st Thursday in August | 12. The Special Program Review Report and Action Plan is presented to the GME Executive Committee and to the GMEC. |

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Appendix C.2.

Special Program Review Proposal

Program to be reviewed:

Month/Year to be reviewed:

Academic Year to be evaluated:

Panel Members to include:

Interviewees to include:

Program Director:

Associate/Assistant Program Director(s):

Quality Champion (if applicable):

Faculty Development Leader (if applicable):

Program Coordinator:

Residents/Fellows:

Representative Core Faculty:

Core Program Director (if applicable):

Date to be presented to the Compliance & Accreditation Standing Committee:

Date to be presented to the GMEC Executive Committee:

Date to be presented to the GMEC:

All proceedings and records of the Graduate Medical Education Committee are confidential and all professional review actions and communications made to the Graduate Medical Education Committee are privileged under Texas and federal law. Tex. Occ. Code Ann. Chps. 151 & 160; Tex Health and Safety Code § 161.032; and 42 U.S.C. 11101 et seq.
Rationale for the SPR:

All proceedings and records of the Graduate Medical Education Committee are confidential and all professional review actions and communications made to the Graduate Medical Education Committee are privileged under Texas and federal law. *Tex. Occ. Code Ann. Chaps. 151 & 160; Tex Health and Safety Code § 161.032; and 42 U.S.C. 11101 eef seg.*
Appendix C.3.

Special Program Review
Report and Action Plan

Program:

Month/Year Reviewed:

Academic Year Evaluated:

Panel Members:

Interviewees:

Program Director:

Associate/Assistant Program Director(s):

Quality Champion (if applicable):

Faculty Development Leader (if applicable):

Program Coordinator:

Residents/Fellows (if applicable):

Representative Core Faculty (if applicable):

Core Program Director (if applicable):

Date presented to the Compliance & Accreditation Standing Committee:

Date presented to the GMEC Executive Committee:

Date presented to the GMEC:

All proceedings and records of the Graduate Medical Education Committee are confidential and all professional review actions and communications made to the Graduate Medical Education Committee are privileged under Texas and federal law. Tex. Occ. Code Ann. Chps.151 & 160; Tex Health and Safety Code §161.032; and 42 U.S.C. 11101 et seq.
Rationale for the SPR:

Program Leadership Meeting

☐ Document Review
   Comments:

☐ Action Plan Review
   Comments:

☐ Program Resource Review
   Comments:

☐ Other
   Comments:

Residents/Fellows Meeting

☐ ACGME Resident Survey Review
   Comments:

☐ Action Plan Review
   Comments:

☐ Procedure/Case Numbers Review
   Comments:

☐ Other
   Comments:

Core Faculty Meeting

☐ ACGME Faculty Survey Review
   Comments:

☐ Action Plan Review

All proceedings and records of the Graduate Medical Education Committee are confidential and all professional review actions and communications made to the Graduate Medical Education Committee are privileged under Texas and federal law. Tex. occ. code ann. chps.151 & 160; Tex Health and Safety Code 161.032; and 42 U.S.C. 11101 et seq.
Comments:

☐ Program Resources Review

Comments:

☐ Other

Comments:
## Action Plan

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Addendum D

Pre Self-Study Review (PSSR) Protocol

Effective January 1, 2017

The revised ACGME Institutional Requirements (effective July 1, 2014) section 1.B.4. a) (GMEC Responsibilities) includes but is not limited to: oversight of the institution and ACGME-accredited programs (1.B.4. a (1)), the quality of the working environment (1.B.4.a (2)), the quality of the educational experiences (1.B.4.a (3)), and the ACGME-accredited programs’ annual evaluation and improvement activities (1.B.4.a (4)).

Missing are requirements for an internal review at the mid-point of a program's accreditation cycle. But, according to the ACGME, the GMEC must implement a process for continuous improvement for all ACGME-accredited programs. The Pre Self-Study Review (PSSR) is part of this process.

The PSSR Process (See sample timeline in Appendix D.1.)

Programs will be assigned a date by which the program self-study materials must be complete. This specific date will be assigned by the GME Office, according to the GME Program Oversight Calendar. The multi-step process is outlined below:

1. The program will receive a reminder notification one year in advance from the GME Office of the due date for completion of the program self-study. The program will be contacted by the GME Office to schedule their PSSR for that month.
2. The program assembles the Self-Study Committee (SSC).
3. The SSC engages program leadership, faculty, trainees and staff in a discussion of program aims.
4. The SSC reviews the SWOTs and Action Plans to determine ongoing threats and opportunities.
5. The SSC aggregates and analyzes data to generate a longitudinal assessment of the program’s improvement.
6. The SSC obtains stakeholder input.
7. The SSC interprets the data and aggregates the self-study findings.
8. The SSC discusses the findings with stakeholders.
9. The SSC completes the Self-Study Summary Document (See Appendix D.2.) and upload into New Innovations.
10. The PSSR will be conducted and a Pre Self-Study Review Report (see Appendix D.3.) will be generated.
11. The GMEC Compliance & Accreditation Standing Committee will review the Pre Self-Study Review Report and either:
   a. Accept as submitted
   b. Ask for clarification/additional documentation and create an action plan
   c. Determine the need for a Special Program Review (SPR)
12. The Pre Self-Study Review Report will be presented to the GME Executive Committee and to the GMEC.
**PSSR Materials**

In addition to the materials required for the APE, the following will be required for the PSSR:

- All APE Minutes and Action Plans since the date of the program’s transition into the Next Accreditation System (NAS). This will be July 1, 2013 for the seven early adopters or July 1, 2014 for all other programs.
- The Self-Study Document

These materials must be uploaded into Ni no later than 10 business days prior to the scheduled PSSR.

**The PSSR Participants and Meeting**

The PSSR will be conducted by the chair (Associate Dean for GME) and co-chair (Assistant Dean for GME) of the GMEC Compliance and Accreditation Standing Committee. Interviewees will include members of the Self-Study group and the Program Leadership.

Reviews will be scheduled for 8:30-11:00 am:

- 8:30-9:45 am  Meeting with SSC
- 9:45-10:00 am  Break
- 10:00-11:00 am  Meeting with Program Leadership

**PSSR Report**

**Report:** The co-chairs will compose a written report. The report will be submitted to the GMEC Compliance and Accreditation Standing Committee. The Pre Self-Study Review Report will be submitted to the GME Executive Committee and to the GMEC.

**GMEC Monitoring of Outcomes**

The GMEC Compliance and Accreditation Standing Committee will review the Pre Self-Study Review Report at its monthly meeting as designated by the GME Program Oversight Calendar and either:

a. Accept as submitted
b. Ask for clarification/additional documentation
c. Determine the need for a Special Program Review (SPR)

A templated summary report will be created and presented by the GMEC Compliance and Accreditation Standing Committee to the GMEC.
Appendix D.1.

Sample Timeline for PSSR Process

Program with an "April" assignment on the GMEC Oversight Calendar

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>April</td>
<td>1. The program will receive a reminder notification of the due date for completion of the program Self-Study.</td>
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<tr>
<td>January</td>
<td>2. The program will receive a reminder notification of the due date for completion of the program component of the APE process.</td>
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<td>3. The program must update ADS.</td>
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<td>4. The program completes the APE form in New Innovations.</td>
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<tr>
<td></td>
<td>5. The SSC conducts the SS.</td>
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<tr>
<td>April</td>
<td>6. The program submits the Self-Study Summary Document (through New Innovations) by the assigned due date.</td>
</tr>
<tr>
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<td>7. The PSSR will be conducted and a Pre Self-Study Review Report will be generated.</td>
</tr>
<tr>
<td>4th Monday in April</td>
<td>8. The GMEC Compliance &amp; Accreditation Standing Committee will review the Pre Self-Study Review Report.</td>
</tr>
<tr>
<td>2nd Tuesday in May</td>
<td>9. The Pre Self-Study Review Report is presented to the GMEC.</td>
</tr>
</tbody>
</table>
Appendix D.2.
Self-Study Summary

Use this standard template for aggregating and submit information from the Self-Study for core programs and larger subspecialty programs. Smaller subspecialty programs may use the Self-Study Summary Short Form.

After completing the Self-Study, provide responses to the first seven items below (the last item is optional).

The deadline for uploading the Self-Study Summary into the Accreditation Data System is the last day of the month the Review Committee indicated for the program’s first site visit in the Next Accreditation System. (For example, if the Review Committee indicated **October 2017** as the date of the first site visit, the document must be uploaded by **October 31, 2017**.)

**Program Name:**

**Program Number:**

**Self-Study Date (Month, Year):**

**Note**

_The documents will be used to assess the program’s aims and environmental context, as well as the process used for the Self-Study and how this facilitates program improvement._

_Do NOT provide information on areas for improvement identified during the Self-Study. A separate document to be submitted 12 to 18 months after initiating the Self-Study will request information on improvements realized in areas identified in the Self-Study._
Program Description and Aims

Describe the program and its aims, using information gathered during the Self-Study.

Item 1: Program description

Provide a brief description of the residency/fellowship program, as you would to an applicant or a prospective faculty member. Discuss any notable information about the program. (Maximum 250 words)

Item 2: Program Aims

Based on information gathered and discussed during the Self-Study, describe the program's aims. (Maximum 150 words)

Item 3: Program activities to advance the aims

Describe current activities that have been, or are being, initiated to promote or further these aims. (Maximum 250 words)

Environmental Context

Summarize the information on the program's environmental context that was gathered and discussed during the Self-Study.

Item 4: Opportunities for the program

Based on the information gathered and discussions during the Self-Study, describe important opportunities for the program. (Maximum 250 words)

Item 5: Threats facing the program

Based on the information gathered and discussions during the Self-Study, describe any real or potential significant threats facing the program. (Maximum 250 words)

Significant Changes and Plans for the Future

Item 6a: Describe significant changes and improvements made in the program over the past five years. (Maximum 250 words)

Item 6b: Project your vision and plans for the program for the coming five years. (Maximum 250 words)
Item 6c: Based on the plans described in the previous item, describe what will “take this to the next level.” (Maximum 200 words)

Note: In your response, discuss what the “next level” will look like, the envisioned steps and activities to achieve it, and the resources needed.

Self-Study Process

Item 7a: Describe Elements of the Self-Study process for your program.

Provide information on your program’s Self-Study, including who was involved, how data were collected and assessed, how conclusions were reached, and any other relevant information. (Maximum 300 words)

<table>
<thead>
<tr>
<th>Who was involved in the Self-Study (by title)?</th>
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<tr>
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<tr>
<td>How were data analyzed, and how were conclusions reached?</td>
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<td></td>
</tr>
<tr>
<td>How were areas for improvement prioritized?</td>
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<td></td>
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</tbody>
</table>

Item 7b: Describe the core program’s role in the Self-Study(ies) of all dependent subspecialty program(s). (Maximum 150 words)

Note: If this is a solo core program or a dependent or “grandfathered” freestanding subspecialty program, skip this item.

OPTIONAL Item 8: Learning that occurred during the Self-Study

Describe learning that occurred during the Self-Study. This information will be used to identify potential best practices for dissemination. (Maximum 200 words)
Appendix D.3.

Pre Self-Study Review Report

Program:

Date Reviewed:

Academic Year Evaluated for APE:

Reviewers:

Interviewees:

  Self-Study Committee Members:

  Program Leadership:

    Program Director:

    Program Coordinator:

Date presented to the Compliance & Accreditation Standing Committee:

Date presented to the GME Executive Committee:

Date presented to the GMEC:

Review of Program Description:

Review of Program Aims:

Review of Activities to advance the aims:

Review of the Opportunities for the program:

Review of Threats to the program:

Review of Program Evaluation Committee (PEC) and the Annual Program Evaluation (APE) process:
Review of the Self-Study process:

<table>
<thead>
<tr>
<th><strong>Self-Study Committee (SSC)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data reviewed by the SSC</strong></td>
<td></td>
</tr>
<tr>
<td><strong>How were the data analyzed?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>How were conclusions reached?</strong></td>
<td></td>
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<tr>
<td><strong>How were areas prioritized for improvement?</strong></td>
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<tr>
<td><strong>Any other information relevant to understanding the self-study process for this program</strong></td>
<td></td>
</tr>
</tbody>
</table>

Summary:

Of note from the APE materials that were included in the PSSR packet:

Of concern are the numerous areas of non-compliance on the most recent ACGME Resident Survey Summary:

Of concern are the numerous areas of non-compliance on the most recent ACGME Resident Survey Summary:

General Comments:
Addendum E

Self-Study Review Protocol (SS) Protocol

Effective January 1, 2017

The SS Process (See sample timeline in Appendix E.1.)

Programs will receive notification from the ACGME indicating the due date of the Self-Study. The multi-step process is outlined below:

1. The program will receive a reminder notification from the ACGME of the due date for completion of the program self-study.
2. The program assembles the Self-Study Committee (SSC).
3. The SSC engages program leadership, faculty, trainees and staff in a discussion of program aims.
4. The SSC reviews the SWOTs and Action Plans to determine ongoing threats and opportunities.
5. The SSC aggregates and analyzes data to generate a longitudinal assessment of the program’s improvement.
6. The SSC obtains stakeholder input.
7. The SSC interprets the data and aggregates the self-study findings.
8. The SSC discusses the findings with stakeholders.
9. The SSC completes the Self-Study Summary Document (See Appendix E.2. or E.3.) and uploads into New Innovations.
10. GME Faculty will review the Self-Study Document and provide verbal feedback to the SSC Chair and Program Leadership.
Appendix E.1.

Sample Timeline for SS Process

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. The program will receive a reminder notification from the ACGME of the due date for completion of the program Self-Study.</td>
</tr>
<tr>
<td></td>
<td>2. The SSC conducts the SS.</td>
</tr>
<tr>
<td>2 months prior to the SS</td>
<td>3. The program submits the <strong>Self-Study Summary Document</strong> (see Appendix E.2. [Core Programs] or Appendix E.3. [Subspecialty Programs] through New Innovations) to the GME Office by the assigned due date.</td>
</tr>
<tr>
<td>due date</td>
<td>4. The GME Office with contact the program to schedule a meeting with the SSC Chair, the Program Director and Program Coordinator to provide feedback on the <strong>Self-Study Summary Document</strong>. The need for follow up and revisions will be determined at this time.</td>
</tr>
</tbody>
</table>
Appendix E.2.
Self-Study Summary

Use this standard template for aggregating and submit information from the Self-Study for core programs and larger subspecialty programs. Smaller subspecialty programs may use the Self-Study Summary Short Form.

After completing the Self-Study, provide responses to the first seven items below (the last item is optional).

The deadline for uploading the Self-Study Summary into the Accreditation Data System is the last day of the month the Review Committee indicated for the program’s first site visit in the Next Accreditation System. (For example, if the Review Committee indicated October 2017 as the date of the first site visit, the document must be uploaded by October 31, 2017.)

Program Name: ________________________________

Program Number: ________________________________

Self-Study Date (Month, Year): ________________________________

Note
The documents will be used to assess the program’s aims and environmental context, as well as the process used for the Self-Study and how this facilitates program improvement.

Do NOT provide information on areas for improvement identified during the Self-Study. A separate document to be submitted 12 to 18 months after initiating the Self-Study will request information on improvements realized in areas identified in the Self-Study.
Program Description and Aims
Describe the program and its aims, using information gathered during the Self-Study.

Item 1: Program description
Provide a brief description of the residency/fellowship program, as you would to an applicant or a prospective faculty member. Discuss any notable information about the program. (Maximum 250 words)

Item 2: Program Aims
Based on information gathered and discussed during the Self-Study, describe the program's aims. (Maximum 150 words)

Item 3: Program activities to advance the aims
Describe current activities that have been, or are being, initiated to promote or further these aims. (Maximum 250 words)

Environmental Context
Summarize the information on the program's environmental context that was gathered and discussed during the Self-Study.

Item 4: Opportunities for the program
Based on the information gathered and discussions during the Self-Study, describe important opportunities for the program. (Maximum 250 words)

Item 5: Threats facing the program
Based on the information gathered and discussions during the Self-Study, describe any real or potential significant threats facing the program. (Maximum 250 words)

Significant Changes and Plans for the Future
Item 6a: Describe significant changes and improvements made in the program over the past five years. (Maximum 250 words)

Item 6b: Project your vision and plans for the program for the coming five years. (Maximum 250 words)
Item 6c: Based on the plans described in the previous item, describe what will “take this to the next level.” (Maximum 200 words)

Note: In your response, discuss what the “next level” will look like, the envisioned steps and activities to achieve it, and the resources needed.

Self-Study Process

Item 7a: Describe Elements of the Self-Study process for your program.

Provide information on your program’s Self-Study, including who was involved, how data were collected and assessed, how conclusions were reached, and any other relevant information. (Maximum 300 words)

<table>
<thead>
<tr>
<th>Who was involved in the Self-Study (by title)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How were data analyzed, and how were conclusions reached?</td>
</tr>
<tr>
<td>How were areas for improvement prioritized?</td>
</tr>
</tbody>
</table>

Item 7b: Describe the core program’s role in the Self-Study(ies) of all dependent subspecialty program(s). (Maximum 150 words)

Note: If this is a solo core program or a dependent or “grandfathered” freestanding subspecialty program, skip this item.

Optional Item 8: Learning that occurred during the Self-Study

Describe learning that occurred during the Self-Study. This information will be used to identify potential best practices for dissemination. (Maximum 200 words)
Addendum F

Mock Site Visit

Protocol

Effective January 1, 2017

The MSV Process (See sample timeline in Appendix F.1.)

Programs will receive notification from the ACGME indicating the date of the Site Visit. The multi-step process is outlined below:

1. The program will receive a reminder notification from the ACGME of the date for the Site Visit.
2. Program contacts the GME Office to schedule as Mock Site Visit (MSV).
3. The program must provide all materials requested by the site visitor to the GME Office no later than 10 business days prior to the scheduled MSV.
4. The Mock Site Visit will be conducted.
5. GME Faculty will provide verbal feedback to the Program Leadership at the end of the MSV.
Appendix F.1.

Sample Timeline for SV Process

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The program will receive a notification from the ACGME of the date for the 10-Year Accreditation SV.</td>
</tr>
<tr>
<td>2.</td>
<td>The program contacts the GME Office to schedule the Mock Site Visit (MSV).</td>
</tr>
<tr>
<td>10 business days prior to the scheduled MSV</td>
<td>3. The program submits all materials requested by the site visitor to the GME Office.</td>
</tr>
<tr>
<td></td>
<td>4. The MSV is conducted and the Program Leadership receives verbal feedback.</td>
</tr>
</tbody>
</table>
# Program Evaluation Committee (PEC) and Annual Program Evaluation (APE)

**Policy**

The ACGME requires that all GME programs implement formal processes of program curriculum planning and program evaluation. It is the responsibility of the Program Director to appoint a **Program Evaluation Committee (PEC)**, which is to participate actively in both aspects of the program.

**PEC membership** – The Program Evaluation Committee must be composed of at least three program faculty members (in addition to the Program Director and/or Associate Program Director)* and should include at least one resident (unless there are currently no trainees in the program); must have a written description of its responsibilities (please see the Responsibilities of the Program Evaluation Committee (PEC) template attached to this policy).

*Faculty members of the PEC must be either core or key faculty (as defined by the ACGME Specialty Specific Program Requirements) or faculty responsible for a significant curricular component of the program.

**PEC meeting frequency** - The PEC must meet at least annually to conduct the APE. However, more frequent meetings are recommended to facilitate a process of continuous program improvement.

**PEC responsibilities** – the PEC is required to participate actively in the following:

- Program planning, developing, implementing, and evaluating educational activities of the program
- Reviewing and making recommendations for revision of competency-based curriculum goals and objectives
- Addressing areas of non-compliance with ACGME standards; and
- Reviewing the program annually using evaluations of faculty, residents, and others, as specified below.
- Documentation of formal, systematic evaluation of the curriculum at least annually, and
- Preparation of a written Annual Program Evaluation (APE). This report will be formulated using a template in New Innovations.
- Submit the APE to the GME Office for review by the Compliance and
Accreditation Standing Committee of the GME Committee.

**APE parameters** – essential specific parameters to be monitored, tracked, and incorporated into the APE include all of the following:

- Program goals and objectives
- Resident performance
- Faculty development
- Graduate performance, including performance on the certification examination
- Program quality – as assessed by residents’ confidential written evaluations of the program (at least once/year), faculty members’ confidential written evaluations of the program (at least once/year), and other program evaluation results
- Supervision, transitions of care and progressive responsibility
- Wellness initiatives
- Policies, protocols and procedures
- Previous years APE and Action Plans
- If applicable, Periodic Program Review Report and Action Plan or Special Review Report and Action Plan
- When new deficiencies are identified, or prior deficiencies are noted to recur, the group should prepare an explicit plan of action

**PEC documentation** – the written work product of the PEC includes the following:

- APE report (New Innovations)
- Meeting minutes - Minutes of PEC meetings should be documented. Please see the Program Evaluation Committee (PEC) Minutes template attached to this policy
- Documentation of faculty/resident review of Action Plan - The PEC minutes and action plan should be reviewed and approved by the teaching faculty and documented in faculty meeting minutes. It is suggested that the action plan be reviewed with the residents and appropriate staff
Annual Program Evaluation (APE)

Minutes & Action Plan

Program

Date

Date of the APE meeting:

Date Minutes & Action Plan were reviewed and Approved by teaching faculty:

Please attach the minutes of the meeting where the Minutes & Action Plan were reviewed and approved.

Academic Year reviewed:

Faculty Members of the PEC in attendance:

 Resident/Fellow Members of the PEC in attendance:

Other Members of the PEC in attendance:

Question 1: Program description

Provide a brief description of your residency/fellowship program, as you would to an applicant or a prospective faculty member. Discuss any notable information about this program. (Maximum 250 words)

Question 2: Program aims

Based on information gathered and discussed during the APE, what are the program’s aims? (Maximum 150 words)

Question 3: Program activities to advance the aims

Describe current activities that have been or are being initiated to promote or further these aims. (Maximum 250 words)
Areas reviewed:

- **Resident performance**
  Supporting documents:

- **Faculty development**
  Supporting documents:

- **Graduate performance**
  Supporting documents:

- **Program quality**
  Supporting documents:

- **Supervision, transitions of care and progressive responsibility**
  Supporting documents:

- **Wellness initiatives:**
  Supporting documents:
- **Policies, Protocols & Procedures**
  Supporting documents:
SWOT Analysis

Strengths

Weaknesses

Opportunities

Threats
<table>
<thead>
<tr>
<th>Item</th>
<th>Strategy</th>
<th>Resources</th>
<th>Timeline</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preservation Goals (Strengths)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elimination Goals (Weaknesses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achievement Goals (Opportunities)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance Goals (Threats)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Responsibilities of the Program Evaluation Committee (PEC)

The PROGRAM Program Evaluation Committee (PEC) will participate in:

- planning, developing, implementing, and evaluating educational activities of the program;
- reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
- addressing areas of non-compliance with ACGME standards; and,
- reviewing the program annually using evaluations of faculty, residents, and others, as specified below.

The PEC will be composed of NUMBER faculty and NUMBER residents. The PEC will document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE).

The PEC will monitor and track each of the following areas:

- resident performance
- faculty development
- graduate performance, including performance of program graduates on the certification exam;
- program quality (residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and the program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program);
- supervision, progressive responsibility and transition of care;
Responsibilities of the Program Evaluation Committee (PEC) Template

- wellness initiatives;
- policies, protocols and procedures; and
- progress on the previous year’s action plan.

The PEC will meet annually, at a minimum, and will communicate as appropriate with the PROGRAM Clinical Competency Committee (CCC) about resident Milestone performance trends that are indices of program quality.

The PEC will keep minutes of all meetings using the template provided by the GME Office.
Outgoing Residents
OUT-PROCESSING OF A RESIDENT – RESIGNATION OR TERMINATION

Things to Collect from resident before they leave campus:

1. UT BADGE
2. UHS BADGE
3. VA BADGE
4. ID from any other affiliated institution your resident attends where an ID was issued
5. KEYS: Resident Office Key, Desk Key, and any other institutional keys they may have
6. FLASH DRIVE (if one was given out)
7. SCRUBS (they are allowed 3 sets, check with UHS laundry to find out how many they have )
   If you don’t want to make them bring the scrubs back to campus, they can pay the $30 (3 sets) or the department can pay it.
8. UT LIBRARY BOOKS – if any
9. MEAL CARD – if any
10. Resident can clear out their desk and mail slot/or PD can go get the items for the departing resident.
    a. If there are notebooks, PD needs to go through them page by page to make sure there are no patient identification (names, case numbers, etc.) either to black them out or remove the page from the notebook.

PROGRAM COORDINATOR needs to:

1. Email IRB: IRBMail@uthscsa.edu the IRB Out-processing Protocol form

The table should contain only residents and fellows who are physically departing UTHSCSA

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Expected departure / faculty appointment date</th>
</tr>
</thead>
</table>

- The IRB will take the list, check it against two different databases to see if they are lead investigator on any ongoing research and have not completed an amendment to transfer the lead role to another individual.
- The IRB can only attest to the resident’s/fellow’s research status up to the date the IRB completes its review of the databases.
- The IRB will respond with an email to the program coordinators as to the status.
- The program coordinator will sign-off on item #5 of the UT Clearance Form and attach a copy of the IRB response email.

2. Complete Professional_Liability_BlankForm_Rev_FY13 and have Department Administrator sign it. Email pdf of form to Joann Sanders SandersJ3@uthscsa.edu to have Medical Liability Insurance cancelled. She will send you back confirmation of cancelled insurance.

3. Contact Alumni office, Chantel Maldonado, MaldonadoC4@uthscsa.edu, to ensure resident is taken off the Alumni list as they did not graduate. Chantel will email you back confirmation of database update.

4. Call UHS Laundry at 358-2481 to see how many sets of scrubs need to be returned or paid for (by resident or department). May need to provide employee ID number from badge. Receipt must be given to UHS PSS with Clearance form.
5. FMG’s, if they are on a work VISA, complete the OIS Confirmation of Departure Form and submit to Office of International Services. They will need to sign the Official Clearance Form.

6. Complete/obtain signatures from various departments for each section of the UTHSCSA OFFICIAL CLEARANCE FORM
   a. UT POLICE – turn in UTHSCSA badge, have them sign off
   b. UT Library – check for outstanding books, have them sign off
   c. VA Education Office - have them sign off
      - turn in VA badge at police office near front entrance to VA hospital
   d. UHS – turn in UHS Badge and keys, (rm: SL #aSL22)
      Pager: (1st fl Rm G0124)
      Laundry – Sublevel A: pay for scrubs or turn them in, get a receipt
   e. Put forwarding address, phone number and working email on the clearance form so if you need to contact them for any reason, you will have it available to you.

7. Turn in completed/signed Clearance form and laundry receipt to Marilyn Dahl at Professional Staff Services.

8. Keep a copy of everything you have submitted to various departments—put in resident training file.

PROGRAM DIRECTOR needs to:

1. Email notification that the resident was either terminated, resigned, or reason for leaving, and effective date so resident can be archived and computer access closed.
   a. GME – Wendy Malone BretonW@uthscsa.edu
   b. UHS – Marilyn Dahl Marilyn.Dahl@uhs-sa.com
   c. VA – Robin Risemas robin.risemas@va.gov

2. Notify Texas Medical Board within 30 days of departure date:
   a. Must fill out Texas Medical Board Program Directors Report which can be downloaded from: http://www.tmb.state.tx.us/professionals/physicians/training/notification.php
   b. Coordinator to Fax report to 1-888-550-7516 and (to cover all bases), FEDEX notification to them as well through e-ship global so there is record of when it was delivered.

   TEXAS MEDICAL BOARD
   333 GUADALUPE
   TOWER 3, SUITE 610, MC 240
   AUSTIN, TX 78701
**OFFICIAL CLEARANCE FORM**

Physician ID: ____________

Dr. ____________________________, Department/Division of ________________________________

has officially cleared the following UTHSC, VAH, and University Hospital areas and is eligible to receive his/her Graduate Training Certificate and (if UHS funded) his/her final paycheck.

**NOTE: #19 CANNOT BE COMPLETED UNTIL #1 THROUGH #18 ARE SIGNED OFF BY THE APPROPRIATE PERSONNEL.**

<table>
<thead>
<tr>
<th>THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Program Director or Designee</td>
</tr>
<tr>
<td>2. Library Personnel (Room 3.010)</td>
</tr>
<tr>
<td>3. UT Police (Dental School Garage)</td>
</tr>
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<td></td>
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<tr>
<td>4. Alumni Office</td>
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<td></td>
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<tr>
<td>5. Institutional Review Board</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>6. Office of International Services</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

287
<table>
<thead>
<tr>
<th></th>
<th>Location (Room)</th>
<th>Signature &amp; Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>ACoS for Education (Room D317)</td>
<td></td>
<td>Comments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>[Form VA-0708 attached.</td>
</tr>
<tr>
<td>9.</td>
<td>Doctor’s Workroom (Room GB105)</td>
<td></td>
<td>Comments</td>
</tr>
<tr>
<td>10.</td>
<td>Environmental Management (GL029)</td>
<td></td>
<td>Comments</td>
</tr>
<tr>
<td>11.</td>
<td>Canteen Office (1st floor new bldg.)</td>
<td></td>
<td>Comments</td>
</tr>
<tr>
<td>12.</td>
<td>Respective Service Secretary</td>
<td></td>
<td>Comments</td>
</tr>
<tr>
<td></td>
<td>Pathology (P117); PM&amp;R (115, bldg. 6 Polytrauma); Surgery (E221); Neurology (C324); Medicine (D316); Radiology (Z101); Psychiatry (F112); Geriatrics (A306)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Police Service (Bldg. 4)</td>
<td></td>
<td>Comments</td>
</tr>
<tr>
<td></td>
<td>UNIVERSITY HOSPITAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Medical Records (1st FL, “D”)  Signature &amp; Date  Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Pagers (One Call Ctr.  SL “C”)  Signature &amp; Date  Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pager #  ______________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Laundry Services (Rm. SB 430, Basement, Sky Tower Staff Elevators)  Signature &amp; Date Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Employee Health Clinic (3rd FL “B”)  Signature &amp; Date  Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Registration &amp; ID (SL “D”) After Hours: Dispatch (West Parking Garage “B2”)  Signature &amp; Date ID MUST BE RETURNED AFTER FINAL DAY ON SERVICE Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** #19 CANNOT BE COMPLETED UNTIL #1 THROUGH #18 ARE SIGNED OFF BY APPROPRIATE PERSONNEL.

<table>
<thead>
<tr>
<th></th>
<th>Professional Staff Services (G0124)  Signature &amp; Date  Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Attach proof of updated NPI Information</td>
</tr>
<tr>
<td></td>
<td>[ ] QuickCharge Account Inactivated</td>
</tr>
</tbody>
</table>

Forwarding Address and Email:

UHS will scan and forward completed forms to MedGME@uthscsa.edu.
Graduation
Certificates
Certificate Process

1. Submit a copy of the excel spreadsheet template (attached) of Resident/Fellows/Department to the GME Office electronically no later than **April 1**.

2. GME will then submit an SRF to the Print Shop. When the proof is received, GME will forward to the PC to verify that all the information is correct. If there is more information added after the 1st proof, the department will be charged a fee.
   - Once proof has been verified, GME office will pay for the initial certificate. If, however, there is a reprint due to a misspelling found after the proof is approved by the PC, a name change, a second copy, etc., the department will need to submit a new SRF, and will be responsible for the fees via an IDT.

3. Dr. Nolan’s signature is added by the Print Shop

4. Once the hard copies are received from the Print Shop, GME will take them to the Dean’s office for his signature.

5. When the Dean’s office returns the signed certificates, GME will notify the PC that they are ready to be picked in the GME office.

6. It is the program’s responsibility to scan and keep a copy of the signed certificate.
Resident Certificate Request

<table>
<thead>
<tr>
<th>Name</th>
<th>Classification</th>
<th>Dates</th>
<th>Program Director Signature Block</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Example**

Jane D. Resident, M.D.  Resident, Anesthesiology  July 1, 2014 - June 30, 2017  James N. Rogers, M.D.

Template Format as of 1/1/2017.

1. Decide when you need the certificates -- for graduation, by June 30, etc.
2. Obtain the above information from your graduates or for resident completing training off cycle.
3. Submit the spreadsheet, via email, to the appropriate individual in the GME office **NO LATER THAN 30 DAYS** before you need them.
4. When the Printshop provides the first proof, please review ALL certificates associated with the SRF # and submit changes/corrections altogether.
5. The Printshop allows only two "free" proofs, so please insure you review each certificate carefully.
6. The cost for these "Certificates of Completion" are paid for by GME.

7. The training program's home department will need to provide an IDT in the amount of $25 for the costs of a reprint, 3 or more additional proofs, and/or a rush order.
8. A former resident requesting "new" copy of a lost/destroyed certificate will need to pay $25.
Certificate of Graduate Medical Education

John Doe, M.D.
Resident, Division Name
July 1, 2???, June 30, 2???

Ron Rodriguez, M.D., Ph.D.
Interim Dean
School of Medicine

Robert J. Nolan Jr., M.D.
Interim Designated Institutional Official
Associate Dean for Graduate Medical Education
Distinguished Teaching Professor and Associate Chairman,
Department of Pediatrics

Program Director, M.D.
Professor of Medicine
Program Director, Division Name
Visiting Residents
## Visiting Residents 1 - Observerships

**Policy**

The UTHSCSA is ACGME-accredited as a sponsor of Graduate Medical Education (GME) programs. Under the accreditation standards, as well as the regulations of the Texas Medical Board (TMB), the Joint Commission (TJC), and other regulatory bodies, certain rules apply which govern the institution's process for accepting residents from training programs outside the UTHSCSA who wish to visit this institution and our teaching hospitals for the purpose of medical education. While the primary obligation of the institution is the education of our residents, this policy has been developed to establish some uniformity of experience and to provide guidance to clinical departments that choose to offer observerships to other residents, as well as to the individuals who wish to undertake them.

The availability of clinical experiences to residents from other programs is at the discretion of individual clinical departments, and is based on the departments' availability of resources and preferences. The existence of these guidelines creates no obligation on the part of any clinical department to provide such experiences.

For residents from other training programs desiring clinical experiences within the institution, there are two types of medical experience available. These include:

1. Observerships
2. Clinical Rotations

This policy will address Observerships. Observership is defined as the position of observing patient care in a health care setting, without patient contact; for the specific purpose of gaining medical knowledge. **No research involvement is allowed.** (Further description of the position may be found below in Rules for Observership.)

### Eligibility:

Observerships may be granted on a case-by-case basis to physicians who are graduates of a medical school and who are members in good
standing of a GME program (hereinafter called "residency").

Individuals who may be eligible for observership include the following:
- Residents in good standing in residency programs which are neither ACGME nor AOA accredited

Individuals who are not eligible for observership include the following:
- Residents at ACGME or AOA-accredited programs. These residents should seek a clinical rotation (See Policy on Visiting Residents 2 - Clinical Rotations).
- Physicians who are not currently enrolled as residents in graduate medical education programs
- Individuals who have not yet graduated from medical school. These medical students may qualify for consideration for a Visiting Student Elective. (See http://www.uthscsa.edu/som/srselect/Vstudents.html).

Application Process: Application packet must be received in the GME office no later than 30 business days (US citizen) and 120 business days (visa holders) prior to requested observation start date.

Note: Not all programs accept observers, and programs may require further application documentation, an interview, and/or an additional application fee.

The application packet consists of the following:

1. Completed Visiting Resident 1 – Observership Application and Checklist
2. All documents requested in the Observership Application and Checklist
3. Non-refundable application fee.

Note: Documents not originally written in English must be officially translated into English by a certified translation agency

The application materials should be sent to the program coordinator assigned to the program in which the rotator wishes to observe.

After a preliminary review of the application, the program will ensure the application is complete and forward the packet to the GME Office. The GME Office will present the application to the Designated Institutional Official, who will approve or disapprove the application.
Departmental Process

After approval of the applicant by the GME Office, the department sponsoring the applicant for the observership will be responsible for assisting the applicant to obtain a J-1 Short Term Scholar visa if the applicant is not a U.S. citizen or permanent resident alien. The Office of International Services (OIS) should be contacted regarding the process to obtain the visa. The department will be responsible for all aspects of the visa sponsorship to include the processing of necessary paperwork and all fees as applicable.

Rules for Observership

1. The observer must obtain prior written authorization from the GME Office. Failure to obtain written authorization will be grounds for immediate escort from the premises of the UTHSCSA and/or the teaching hospital(s).
2. The observer must wear appropriate photo identification at all times when on campus or within the teaching hospitals, and must abide by all policies, rules, regulations, and bylaws of UTHSCSA, the residency department, and the teaching hospitals.
3. The observer must be supervised by a faculty physician or designee (other faculty from the same department or a senior-level resident) at all times when in the presence of patients. He/she is not allowed unrestricted access to UTHSCSA, or to the teaching hospitals.
4. The observer must introduce him/herself to the patient as an observer, and must request the patient's permission to be present at the time of clinical visit, procedure, or other patient services. If the patient declines to allow the observer's presence, he/she must leave the area.
5. The observer is not allowed any other direct patient contact. Contact is defined as physically touching, talking with, performing a medical history and/or examination, counseling (patient or patient's family/friends), assisting in surgery or any other procedure, or otherwise interacting with patients, either individually or in the presence of others.
6. The observer cannot make patient chart entries (electronic or hard copy). He/she may not make copies of patient charts (paper or electronic).
7. There is a maximum of two (2) one-month observerships per individual, which may not be extended.
8. No stipend support, compensation, insurance coverage, benefits, or housing will be provided by the UTHSCSA or the teaching hospitals.
9. UTHSCSA may, at its sole discretion, terminate this observership without recourse to due process or appeal process.
10. The observership is performed on a voluntary basis, and the
resident is not employed by UTHSCSA or the teaching hospitals or any affiliated entities.

11. The observer will not receive any academic credit for the experience. The observership does not constitute medical education, graduate medical education, continuing medical education or training leading to licensure or board certification. The observer is not a student, resident, or medical staff member at UTHSCSA, and must not represent him/herself as such. The experience is properly characterized as an "observership."

12. The following activities are permissible for observers:
   a. Participation in grand rounds, seminars, or other didactic activities
   b. Participation in case conferences or chart rounds. Observers who are engaged in this activity may be asked to sign a document acknowledging the responsibilities of confidentiality.
   c. May observe walking rounds with the supervising faculty physician or designee.
   d. May view and discuss patient interactions with the supervising faculty physician or designee, if the patient has agreed to permit observation.
   e. May view and discuss videotapes of patient evaluations, if the patient has agreed to permit observation and videotaping.
   f. May utilize software and hard copy educational resources (teaching software, books, journals) of the Briscoe Medical Library. Access to the internet from computers in the Library, or departments will be in accordance with current standard Health Science Center policies.

13. Upon satisfactory completion of the observership, the program may wish to provide the observer with a certificate of completion of the observership.

Acceptance into an Observership position will not constitute a precedent or guarantee acceptance into further residency training in programs sponsored by UTHSCSA.
# VISITING RESIDENTS 1 – OBSERVERSHIP APPLICATION AND CHECKLIST

**Instructions:** Complete and return the application and checklist to the program in which the observership is desired. **Incomplete application packets will not be processed and will be returned to the applicant.** Packet must be submitted 30 days (US citizens) or 120 days (visa holders) prior to rotation start date.

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<thead>
<tr>
<th>Print Full Name</th>
<th>MD</th>
<th>DO</th>
<th>Other</th>
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<table>
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<tr>
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<tr>
<th>Medical School Address</th>
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<tr>
<th>Sponsoring Inst &amp; Residency Program</th>
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<tr>
<th>Residency Program Address</th>
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<tr>
<th>Dates of Residency</th>
<th>Began:</th>
<th>Expected Completion:</th>
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<tr>
<th>Program Director</th>
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<tr>
<th>Program Director Contact Information</th>
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<thead>
<tr>
<th>Rotation Requested at UTHSCSA</th>
<th>Specialty</th>
<th>Dates</th>
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<tr>
<th>Signature</th>
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<tr>
<th>Today’s Date</th>
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</thead>
</table>

Please mail this application form, checklist, $200.00 (US) application fee (non-refundable), and required documents to the program in which you are applying to do the observership.

Once the application packet has been reviewed and approved by the GME office, a clearance letter will be sent to the program. The program will have final approval of the requested rotation and dates.
### VISITING RESIDENTS 1 – OBSERVERSHIP APPLICATION AND CHECKLIST

- The following documents, **if not originally written in English**, must be officially translated into English by a certified translation agency and submitted to the program.
- For rotators who are not United States citizens or are not a permanent resident, you must obtain a J-1 Short Term Scholar visa that will be in force for the entire duration of the observership.

<table>
<thead>
<tr>
<th>Print Full Name</th>
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</thead>
<tbody>
<tr>
<td>Curriculum Vitae</td>
</tr>
</tbody>
</table>

**Letter** from resident’s Program Director with responsibility for the residency training that addresses the following:

- Authorization and eligibility to pursue international elective experiences, if appropriate
- Current level of training
- Dates resident began and completed Medical School
- Date resident began residency training and anticipated completion date
- Statement that resident is in good standing in the residency program
- Curricular requirements to be met by the observership experience
- Statement of desired observership(s)
- Name of person assuming responsibility for trainee at UTHSCSA

**Additional documentation required. Please attach.**

- Copy of Visa (if applicable)
- Official copy of Medical School transcript with medical school seal
- Notarized copy of Medical School diploma
- Evidence of proficiency with the English language
- Evidence of passing a UTHSCSA Security Background Check
- Evidence of health insurance to cover accidents, illness, etc., while performing the observership

**$200 (US) application fee – non-refundable – certified check made payable to the Office of Graduate Medical Education at UTHSCSA**

Reviewed and approved by Designated Institutional Official, UT Health Graduate Medical Education

______/______/______

(date)

Packet returned to program on ______/_____/______ by ________________________________

**FINAL UTHSCSA PROCESSING (After GME Approval)**

UTHSCSA Residency/Fellowship Training Program Responsibility

- ID Badge
- Check in with the Office of International Affairs
Visiting Residents 2 – Clinical Rotations

Policy Under ACGME accreditation standards, as well as the regulations of the Texas Medical Board (TMB), The Joint Commission (TJC), and other regulatory bodies, certain rules apply which govern the institution's process for accepting residents from training programs outside the UTHSCSA who wish to visit this institution and our teaching hospitals for the purpose of medical education. While the primary obligation of the institution is the education of our residents, this policy has been developed to add some uniformity of experience and guidance to clinical departments that choose to offer clinical rotations, as well as to the individuals who wish to undertake them.

The availability of clinical experiences to residents from other programs is at the discretion of individual clinical departments, and is based on the departments' availability of resources and preferences. The existence of these guidelines creates no obligation on the part of any clinical department to provide such experiences.

For residents from other training programs desiring clinical experiences within the institution, there are two types of medical experience available. These include:

1. Observerships
2. Clinical Rotations

This policy will address Clinical Rotations. A clinical rotation is defined as the position of participating in patient care as a member of a supervised clinical team in a health care setting, with patient contact appropriate for the individual's level of training and performance, for the specific purposes of gaining medical knowledge and experience, and obtaining credit for the experience toward ACGME-accredited training or American Osteopathic Association (AOA)-accredited training.

Eligibility:

Clinical rotations may be granted on a case-by-case basis to physicians who are graduates of a medical school and who are
members in good standing of a GME program (hereinafter called "residency") within an ACGME-accredited institution or AOA-accredited training institution.

Individuals who are not eligible for clinical rotations include the following:

- Residents enrolled in a non-ACGME or non-AOA sponsored program may seek an Observership (see Policy on Visiting Residents 1 - Observerships).
- Physicians who are not currently enrolled as residents in graduate medical education programs
- Individuals who have not yet graduated from medical school

**Length of Rotation:** A clinical rotation shall not exceed three consecutive months. An application can be submitted for an additional 30-day rotation.

**Application Process:** Application packet must be received in the GME office no later than 30 days prior to requested clinical rotation start date. If the visiting resident currently holds a visa, the application must be received 30 days in advance to allow processing through the Office of International Services.

**Note:** Not all programs accept rotators, and programs may require further application documentation, an interview, and/or an additional application fee.

The application packet consists of the following:

1. Completed Visiting Resident 2 – Clinical Rotations Application and Checklist
2. All documents requested in the Clinical Rotation Application and Checklist
3. Non-refundable application fee.

The hosting UTHSCSA program coordinator is responsible for:

1. Communications and coordinating the process to include all paperwork with the prospective clinical rotator.
2. Receiving and reviewing the packet for completeness.
3. Forwarding the packet to GME with a cover memo indicating that the packet is complete and the hosting UTHSCSA program approves the rotation no later than 30 business days prior to the start of the rotation.
4. Ensuring that the applicant has a current Texas PIT for the proposed rotation.
5. Ensuring that the PLA is completed between the rotators home program and the UTHSCSA receiving program.

The UTHSCSA GME Office is responsible for:

1. Ensuring that the application is complete and that the applicant is eligible to apply for the clinical rotation.
2. Presenting the application to the Designated Institutional Official, who will approve or deny the rotation.
3. Entering the clinical rotator’s pertinent information into New Innovations (Ni) and ensuring the rotator’s Ni file is activated 5 days prior to the start of the rotation.
4. Notifying UHS, VA, and the hosting program’s coordinator that the clinical rotator is cleared for the approved rotation.

No stipend support, insurance coverage, or housing will be provided by the UTHSCSA programs or the teaching hospitals.

Upon GME approval for a clinical rotation and with the assistance of the hosting UTHSCSA program coordinator, the resident must satisfy the additional requirements listed below:

1. have a photo identification badge made by the UTHSC Police Office,
2. Satisfy all requirements of the facility through which he/she will rotate (i.e., UHS, VAH).

When all of the requirements have been met the resident may begin his/her clinical rotation, and will be supervised by attending physicians, can write orders, and have all of the privileges and responsibilities of all other residents within GME programs sponsored by UTHSCSA.

Acceptance into a clinical rotation will not constitute a precedent or guarantee acceptance into residency or fellowship training programs sponsored by UTHSCSA.
**VISITING RESIDENTS 2 – CLINICAL ROTATION APPLICATION AND CHECKLIST**

*Instructions: Complete and return the application and checklist to the program in which you desire to do a clinical rotation. Incomplete application packets will not be processed and will be returned to the applicant. Packet must be submitted 30 days (US citizens) or 120 days (visa holders) prior to rotation start date.*

<table>
<thead>
<tr>
<th>Full name as it appears on SSN Card</th>
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</thead>
<tbody>
<tr>
<td>Credentials</td>
</tr>
<tr>
<td>☐ MD</td>
</tr>
<tr>
<td>☐ DO</td>
</tr>
<tr>
<td>☐ Other ___________________________</td>
</tr>
<tr>
<td>Social Security Number</td>
</tr>
<tr>
<td>Home Address</td>
</tr>
<tr>
<td>Phone Numbers</td>
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<tr>
<td>Work __________________ Home _______ Mobile _______________</td>
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<td>Email Address</td>
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<tr>
<td>Medical School</td>
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<tr>
<td>Medical School Address</td>
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<tr>
<td>Address 1</td>
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<tr>
<td>Address 2</td>
</tr>
<tr>
<td>City, State</td>
</tr>
<tr>
<td>Country, Postal Code</td>
</tr>
<tr>
<td>Medical School Graduation Date (MM/DD/YYYY)</td>
</tr>
<tr>
<td>Sponsoring Institution</td>
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<tr>
<td>Specialty</td>
</tr>
<tr>
<td>Residency Program Address</td>
</tr>
<tr>
<td>Address 1</td>
</tr>
<tr>
<td>Address 2</td>
</tr>
<tr>
<td>City, State</td>
</tr>
<tr>
<td>Country, Postal Code</td>
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<tr>
<td>Dates of Residency</td>
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<tr>
<td>Began: ___________ Expected Completion: ___________</td>
</tr>
<tr>
<td>Current Specialty PGY Level</td>
</tr>
<tr>
<td>Program Director</td>
</tr>
<tr>
<td>Program Director &amp; Program Coordinator</td>
</tr>
<tr>
<td>Contact Information</td>
</tr>
<tr>
<td>Initial Program (first year out of medical school)</td>
</tr>
<tr>
<td>Rotation Request at UTHSCSA</td>
</tr>
<tr>
<td>Specialty</td>
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<tr>
<td>Signature</td>
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<tr>
<td>Today’s Date</td>
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</tbody>
</table>

Please mail this application form, checklist, $100.00 (US) application fee (non-refundable), and required documents to the program in which you desire to do a clinical rotation.

The hosting UTHSCSA program will be notified once the application packet has been approved by the GME office, and the program will have final approval of the requested rotation and dates.
VISITING RESIDENTS 2 – CLINICAL ROTATION APPLICATION AND CHECKLIST

Print Full Name

Curriculum Vitae (Please explain any gaps in dates.)
Medical School Documents:
☐ LCME-Accredited Medical School Graduates – provide the following items:
  Copy of Diploma or Final Medical School Transcript (with “conferred on” dates)
  Texas State Medical License (if applicable) OR Texas Physician in Training Permit
  Copy of J-1 Visa (if applicable)

☐ Non-LCME-Accredited Medical School Graduates – provide the following items
  Copy of Diploma (original and English translation) or Final Medical School Transcript (with conferred on dates)
  Valid ECFMG certificate
  Full and Unrestricted license Texas Medical License or Texas Physician In Training Permit
  Copy of J-1 Visa (if applicable)

Letter from resident’s Program Director, co-signed by the DIO or Director of GME addressing the following:
☐ Name of sponsoring institution and current ACGME or AOA accredited training program of the resident
☐ Authorization and eligibility to pursue elective experiences
☐ Statement of desired clinical rotation(s) including curricular requirements and length of rotation
☐ Name of person assuming responsibility for resident at UTHSCSA
☐ Financial source of stipend & benefits during training at UTHSCSA
☐ Current level of training
☐ Dates resident began and completed Medical School
☐ Date resident began residency training and anticipated completion date
☐ Brief description of resident’s prior clinical experiences
☐ Statement that resident is in good standing in the residency program
☐ Copy of Program Letter of Agreement (PLA)

Additional documentation required. Please attach.
☐ Evidence of passing USMLE Steps 1 and 2 or COMLEX Steps 1 and 2
☐ Evidence of health insurance (copy of certificate required)
☐ Proof and source of payment of malpractice insurance (professional liability insurance) during rotation (copy of certificate required)
☐ Ethics and HIPAA Training: Provide proof of training from home program
☐ Evidence of passing a UTHSCSA Security Background Check
☐ Signed Voluntary Disclosure of Social Security Number form
☐ Complete the Confidentiality/Security Acknowledgement Form http://www.uthscsa.edu/GME/documents/confacknowledge.pdf
☐ Evidence of completing the UHS restraint training

$100 (US) Application fee – non-refundable – certified check made payable to the Office of Graduate Medical Education at UTHSCSA

Reviewed and approved by the Designated Institutional Official for Graduate Medical Education

_________________________________________   ________/_______/_______
Signature                                             Date

Packet forwarded to program on _______/_____/______ by ____________________________

Texas Physician in Training Permit or Texas Medical License #_________ and date of expiration ______/_____/______
Academic Year ______
The University of Texas Health Science Center at San Antonio
Housestaff Data Sheet for Rotators

Name: ________________________________
(First) (Middle) (Last) (Degree Type) (Gender)

Local Address: ________________________________
(Street) (City) (State) (Zip Code)

Work e-mail address: ________________________________

Phone Number: ________________________________
(Home) (Cell) (Pager)

Date of Birth: __________ Social Security #: ____________
PIT/License #: ____________

Medical School: ________________________________
(name) (location)

Current Residency/Fellowship Program: ________________________________
(specialty)

List bedside procedures rotator can perform without direct supervision:

Reviewed and Approved by:

__________________________ Date
Rotator's Program Director's Signature

__________________________ Date
Hosting UTHSCSA Program Director's Signature
Please detail your activities each year from your graduation date from medical school through the present. Be sure to include any post-graduate education activities and their locations.

**Example:**

<table>
<thead>
<tr>
<th>Medical School Graduation: 5/31/2004</th>
<th>Accredited Program</th>
<th>Research Year</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>2004-05 PGY 1 Internal Medicine, University of Texas Medical Branch</td>
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<tr>
<td>2005-06 PGY 2 Internal Medicine, University of Texas Medical Branch</td>
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<tr>
<td>2006-07 PGY 3 Internal Medicine, University of Texas Medical Branch</td>
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<td>2007-08 Private practice, Internal Medicine, Galveston, Texas</td>
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<tr>
<td>2008-09 Private practice, Internal Medicine, Galveston, Texas</td>
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<tr>
<td>2009-10 Private practice, Internal Medicine, San Antonio, Texas</td>
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<td></td>
<td>☒</td>
</tr>
<tr>
<td>2010-11 Gastroenterology fellowship, UTHSCSA</td>
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Medical School Graduation ____________________________

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<th>(year)</th>
<th>(activity, or program)</th>
<th>Accredited Program</th>
<th>Research Year</th>
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307
Military Rotators
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<tr>
<th>Section 4</th>
<th>Program Policies &amp; Procedures</th>
<th>Effective:</th>
<th>May 2013</th>
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<tbody>
<tr>
<td>Policy 4.4.3.</td>
<td>Visiting Residents 3 – Military Rotators</td>
<td>Revised:</td>
<td>May 2017</td>
</tr>
<tr>
<td>Responsibility:</td>
<td></td>
<td>Responsibility:</td>
<td>Designated Institutional Official</td>
</tr>
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</table>

**Visiting Residents 3 – Military Rotators**

**Policy**
The UTHSCSA is ACGME-accredited as a sponsor of Graduate Medical Education (GME) programs. Under the accreditation standards, as well as the regulations of the Texas Medical Board (TMB), The Joint Commission (TJC), and other regulatory bodies, certain rules apply which govern the institution's process for accepting military rotators. While the primary obligation of the institution is the education of our residents, this policy has been developed to add some uniformity of experience and guidance to clinical departments that choose to offer rotations to military residents.

The availability of clinical experiences to military rotators from other programs is at the discretion of individual clinical departments, and is based on the departments' availability of resources and preferences. The existence of these guidelines creates no obligation on the part of any clinical department to provide such experiences.

**Eligibility:**

Clinical Rotations of any length may be granted on a case-by-case basis to military rotators who are graduates of a medical school and who are members in good standing in a military GME program within an ACGME accredited institution.

**Application Process:** Application packet must be received in the GME office no later than 15 business days prior to requested clinical rotation start date.

The application packet consists of the following:

1. Completed Military Rotators Processing Checklist (Policy 4.4.3.1) for UTHSCSA GME Office
2. All documents requested in the checklist

The UTHSCSA program coordinator is responsible for:

1. Receiving and reviewing the packet for completeness.
2. Notifying the appropriate military program coordinator that the packet is complete and the rotation(s) is approved.
3. Forwarding the packet to GME (this indicates that the packet is complete and the UTHSCSA program approves the rotation) and ensuring the packet is forwarded to the GME office in no later than 15 business days of the start of the rotation.

The UTHSCSA GME Office is responsible for:

1. Entering the military rotator’s pertinent information into New Innovations (Ni) and ensuring the rotator’s Ni file is activated 10 days prior to the start of the rotation.
2. Notifying UHS, VA, military program coordinator, and the hosting program’s coordinator that the military rotator is cleared for the approved rotation.

After the military rotator has been cleared, the hosting program coordinator must enter a block schedule into New Innovations for the rotator.

After the military rotator is cleared, he/she must, with assistance from the hosting program coordinator:

1. Obtain a photo identification badge from UTHSC Police Office to include access to the MARC and/or CTRC (if necessary),
2. Complete all of the required paperwork and training of the facility through which he/she will rotate (i.e., UHS, VAH).
3. Must obtain a resident parking permit from the GME office in order to park at the MARC and/or CTRC (if necessary).

At that time, the military rotator has all of the privileges and responsibilities of all other residents within GME programs sponsored by UTHSCSA. During the rotation period, all bedside and clinical procedures will be performed with direct supervision.

No stipend support, insurance coverage, or housing will be provided by the UTHSCSA or the teaching hospitals.

The rotation packet is valid for the entire academic year; however, residents will be cleared per contiguous rotation within a single hosting program.

Multiple, non-contiguous rotations within the same program require reactivation of the clearance. The hosting program’s coordinator must notify the GME office at least 7 business days prior to, but no more than 30 business days in advance of the start of the rotation.

Multiple rotations in different programs require the approval of each hosting program.
Military rotators are expected to out-process through the GME Office at the conclusion of each contiguous rotation block.
Military Rotators Processing Checklist

Instructions: The coordinator of the hosting UTHSCSA program is responsible for submitting this packet in its entirety to the GME Office no later than 15 business days prior to the intended start date of the UTHSCSA rotation, but no more than 60 business days in advance. Incomplete packets will NOT be processed or accepted. If the packet is not complete 15 business days prior to the intended start date of the rotation, a timely start date is not guaranteed. Expedited applications will incur a charge of $100 which must accompany the packet.

Packets will NOT be accepted directly from rotators or from SAUSHEC administrative staff. Receipt of the packet from the UTHSCSA program indicates that the program has approved of the rotation and that the education of UTHSCSA trainees will not be compromised by the presence of these additional learners.

Complete packets contain:

<table>
<thead>
<tr>
<th>SAUSHEC Provided</th>
<th>UTHSCSA Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Housestaff Datasheet -- Timeline (pg. 2 of datasheet) and SSN must be filled in.</td>
<td></td>
</tr>
<tr>
<td>Signed Notice of Voluntary Disclosure of Social Security Number</td>
<td></td>
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<tr>
<td>Current CV showing all years of post-graduate training</td>
<td></td>
</tr>
<tr>
<td>Copy of Medical School diploma or final transcript showing “conferred on date”</td>
<td></td>
</tr>
<tr>
<td>Documentation of HIPAA training – from your home program</td>
<td></td>
</tr>
<tr>
<td>Documentation of Ethics training – from your home program</td>
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<tr>
<td>Signed Confidentiality and Security Acknowledgement Form</td>
<td></td>
</tr>
<tr>
<td>Copy of PLA for the rotation</td>
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</tr>
</tbody>
</table>

After GME processes packet, GME will notify participating institutions such as UHS and VA as well as involved PC’s of the GME Office’s clearance. It is the responsibility of the hosting UTHSCSA program’s PC to ensure visiting rotators have proper clearance from these participating institutions prior to beginning their rotations.

Upon completion of each rotation, the resident’s access is deactivated. If the military rotator will be participating in multiple rotations at UTHSCSA, it is the responsibility of the hosting UTHSCSA program’s PC to notify the GME office at least 7 business days prior to the intended start date, but no more than 30 business days in advance, for reactivation.

Rotator’s Name: ____________________________

<table>
<thead>
<tr>
<th>Program</th>
<th>Start Date</th>
<th>End Date</th>
<th>UTHSCSA Contact Information</th>
<th>SAUSHEC Contact Information</th>
</tr>
</thead>
</table>

Revised: May 2017
Academic Year ________
The University of Texas Health Science Center at San Antonio
Housestaff Data Sheet for Rotators

Name: ____________________________________________
(Last) (First) (Middle) (Degree Type) (Gender)

Local Address: ___________________________________
(Street) (City) (State) (Zip Code)

Work e-mail address: __________________________________

Phone Number: ( ) ( ) ( ) ( )
(Home) (Cell) (Pager)

Date of Birth: __ / __ / ___ Social Security #: _____ - _____ PIT/License #: ______________________

Medical School: ________________________________
(name) (location)

Current Residency/Fellowship Program: _____________
(specialty)

List bedside procedures rotator can perform without direct supervision:

__________________________________________________
__________________________________________________

________________________  _______________________
Program Director’s Signature   Date
Please detail your activities each year from your graduation date from medical school through the present. Be sure to include any post-graduate education activities and their locations.

**Example:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity, Institution, Location</th>
<th>Accredited Program</th>
<th>Research Year</th>
<th>Not Applicable</th>
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<tr>
<td>2004-05</td>
<td>PGY 1 Internal Medicine, University of Texas Medical Branch</td>
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<tr>
<td>2005-06</td>
<td>PGY 2 Internal Medicine, University of Texas Medical Branch</td>
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<td>PGY 3 Internal Medicine, University of Texas Medical Branch</td>
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<tr>
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<td>2008-09</td>
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<td>2009-10</td>
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<tr>
<td>2010-11</td>
<td>Gastroenterology fellowship, UTHSCSA</td>
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Medical School Graduation ____________________________

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</table>

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NOTICE FOR VOLUNTARY DISCLOSURE OF SOCIAL SECURITY NUMBER
School of Medicine Resident Rotators

Disclosure of your social security number (SSN) is requested from you in order for the University of Texas Health Science Center at San Antonio (UTHSCSA) to provide accurate information to affiliated hospitals for Medicare reporting. No statute or other authority requires that you disclose your SSN for that purpose. Failure to provide your SSN, however, may result in your being denied the opportunity to complete clinical rotations. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable laws.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information the University of Texas Health Science Center at San Antonio collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have The University of Texas Health Science Center at San Antonio correct information about you that is held by The University of Texas Health Science Center at San Antonio and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that The University of Texas Health Science Center at San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.

You may send any requests to:
The Office of the Vice President/Chief Financial Officer
By mail to: 7703 Floyd Curl Drive, San Antonio, TX 78229-3900
By e-mail to: PublicInfo@uthscsa.edu
By fax to: (210) 567-7027
In person at: Academic and Administration Building, Room 442

***************************************************************************************************************

CONSENT FOR RELEASE

I consent for the release of my social security number for the stated purposes above.

Print Name: ______________________
Signature: ______________________
Date: ________________

Please return form to
Graduate Medical Education * 7703 Floyd Curl Drive MC 7790 * San Antonio, Texas 78229-3900
Confidentiality/Security Acknowledgement

The University of Texas Health Science Center at San Antonio (UTHSCSA) has a legal and ethical responsibility to safeguard the privacy of all patients and protect confidentiality and security of all health information. During your employment or affiliation with UTHSCSA you may hear information related to a patient’s health or read or see computer or paper files containing confidential health information, whether or not you are directly involved in providing patient services. You may also create documents containing confidential patient information, if it is part of your job description and/or as directed to do so by your supervisor.

As part of your employment or affiliation with UTHSCSA, you must strictly adhere to the following regarding confidentiality and security of patient information:

✓ Confidential Health Information. I will regard patient confidentiality as a central obligation of patient care. I understand that all information, which in any way may identify a patient or which relates to a patient’s health, must be maintained in the strictest confidence. Except as permitted by this Acknowledgement, I will not at any time during or after my employment or affiliation speak about or share any patient information with any person or permit any person to examine or make copies of any patient reports or other documents that I come into contact with or which I create, except as allowed within my job duties or by patient authorization.

✓ Permitted Use of Patient Information. I understand that I may use and disclose confidential patient information only to other providers of health care services, if the purpose of the disclosure is for treatment, consultation, or referral of the patient. If my job description allows, I may also disclose information for payment and billing purposes and/or internal operations, such as use for internal quality studies and for internal education activities.

✓ Prohibited Use and Disclosure. I understand that I must not access, use or disclose any patient information for any purpose other than stated in this Acknowledgement. I may not release patient records to outside parties except with the written authorization of the patient, the patient’s representative, or for other limited or emergency circumstances. Special protections apply to mental health records, records of drug and alcohol treatment, and HIV related information. I must neither physically remove records containing patient information from the provider’s office, clinic, or facility, nor alter or destroy such records. Personnel who have access to patient records must preserve their confidentiality and integrity, and no one is permitted access to health information without a legitimate, work-related reason.

I also agree to immediately report to my supervisor or to the UTHSCSA Privacy Officer any non-permitted disclosure of confidential patient information that I make by accident or in error. I agree to report any use or disclosure of
confidential patient information that I see or know of others making that may be a wrongful disclosure.

✓ Safeguards. In the course of my employment or affiliation if I must discuss patient information with other healthcare practitioners in the course of my employment or affiliation, I will use discretion to ensure that others who are not involved in the patient’s care cannot overhear such conversations. I understand that when confidential patient information is within my control, I must use all reasonable means to prevent it from being disclosed to others except as permitted by this Acknowledgement.

Protecting the confidentiality of patient information means protecting it from unauthorized use or disclosure in any format, oral/verbal, fax, written, or electronic/computer.

✓ Computer Security. If I keep any identifiable patient information on a personal digital assistant (PDA), laptop, or other electronic device, I will ensure that my supervisor knows I am using it and has approved such use. I agree not to send patient information in an e-mail unless my supervisor directs me to do so in an emergency. I will not attempt to access information by using a user identification code or password other than my own, nor will I release my user identification code or password code to anyone, or allow anyone to access or alter information under my identity. I will ensure that my virus protection software is updated on a routine basis (once per week) and that I back up any confidential information using approved back up procedures.

✓ Physical Security. I will take all reasonable precautions to safeguard confidential information. These precautions include using lockable file cabinets, locking office doors, securing data disks, tapes or CDs, using a password protected screen saver, etc. I agree to store my electronic media in recommended containers and store back up media in approved locations.

✓ Return or Destruction of Information. If my employment or affiliation with UTHSCSA requires that I take patient information off the UTHSCSA campus or off the property of UTHSCSA affiliates, I will ensure that I have UTHSCSA’s or the other facility’s permission to do so. I will protect patient information from unauthorized disclosure to others, and I will ensure that all patient information is returned to the appropriate facility.

Unless specifically stated in my job description, I am not authorized to destroy any type of original patient information maintained in any medium, i.e., paper, electronic, etc.

✓ Termination. When I leave my employment or affiliation or complete my training or residency at UTHSCSA, I will ensure that I take no identifiable patient information with me, and I will return all patient information in any format to the
UTHSCSA or other appropriate facility. If it is not original documents, but rather my own personal notes, I must ensure that such information is destroyed in a manner that renders it unreadable and unusable by anyone. Discharge or termination, whether voluntary or not, shall not affect my ongoing obligation to safeguard the confidentiality and security of patient information and to return or destroy any such information in my possession.

✓ Violations. I understand that violation of this Acknowledgement may result in corrective action, up to and including termination of my employment or affiliation. In addition, violation of privacy or security regulations could also result in fines or jail time.

✓ Disclosures Required by Law. I understand that I am required by law to report suspected child or elder abuse to the appropriate authority. I agree to cooperate with any investigation by the Department of Health and Human Services or any oversight agency, such as to help them determine if UTHSCSA is complying with federal or state privacy laws.

I understand that nothing in this Acknowledgement prevents me from making a disclosure of confidential patient information if I am required by law to make such a disclosure.

I understand that if I believe in good faith that UTHSCSA has engaged in conduct that is unlawful or otherwise violates clinical or professional standards, or that the care, services, or conditions provided by the UTHSCSA potentially endangers one or more patients, workers, or the public, a disclosure of confidential information may be made, but only to the appropriate public authority and/or to the attorney retained by me for the purpose of determining legal options with regard to the suspected misconduct.

My signature, on the following page, acknowledges that I have read the terms and conditions of this Acknowledgement. The signature page will be maintained by my department supervisor.

NOTE: To access specific policies regarding privacy or security issues, please refer to the Handbook of Operating Procedures (HOP), available at http://www.uthscsa.edu/hop2000/. Security policies are located in Chapter 5 and privacy policies in Chapter 11.
Confidentiality/Security Acknowledgement
Signature Page

By my signature below, I acknowledge that I have read the terms and conditions of the Confidentiality/Security Acknowledgement. I am maintaining the three page Acknowledgement for my own records.

Signature:

Please circle
UTHSCSA Employee  Resident/Intern  Student  Non-employee

Printed name: ________________________________

Date: ________________________________

Work Phone: ________________________________

Department: ________________________________
### Acronyms

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<tr>
<th>Acronym</th>
<th>Description</th>
<th>Website</th>
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</thead>
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<tr>
<td>AAMC</td>
<td>Association of American Medical Colleges</td>
<td><a href="http://www.aamc.org">www.aamc.org</a></td>
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<tr>
<td>ABMS</td>
<td>American Board of Medical Specialties</td>
<td><a href="http://www.abms.org">www.abms.org</a></td>
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<tr>
<td>ACGME</td>
<td>Accreditation Council for Graduate Medical Education</td>
<td><a href="http://www.acgme.org">www.acgme.org</a></td>
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<tr>
<td>ADS</td>
<td>Accreditation Data System</td>
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<td>American Hospital Association</td>
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<td>Association for Hospital Medical Education</td>
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<td><a href="http://www.ama-assn.org">www.ama-assn.org</a></td>
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<tr>
<td>AMG</td>
<td>American Medical Graduate</td>
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<tr>
<td>APD</td>
<td>Associate Program Director</td>
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<tr>
<td>APE</td>
<td>Annual Program Evaluation</td>
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<tr>
<td>BCMS</td>
<td>Bexar County Medical Society</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>CCC</td>
<td>Clinical Competency Committee</td>
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<tr>
<td>CCRI</td>
<td>Children’s Cancer Research Institute (Greehey)</td>
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<tr>
<td>CBE</td>
<td>Competency Based Education</td>
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<tr>
<td>COMLEX</td>
<td>Comprehensive Osteopathic Medical Licensing Examination</td>
<td><a href="http://www.nbome.org">www.nbome.org</a></td>
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<td>CME</td>
<td>Continuing Medical Education</td>
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<tr>
<td>CPR</td>
<td>Common Program Requirements</td>
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<tr>
<td>CSA</td>
<td>Clinical Skills Assessment, Part of USMLE Step 2</td>
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<td>CHOSA</td>
<td>Childrens’ Hospital of San Antonio</td>
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<tr>
<td>CTRC</td>
<td>Cancer Therapy and Research Center</td>
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<tr>
<td>CV</td>
<td>Curriculum Vitae</td>
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<td>Drug Enforcement Administration</td>
<td><a href="http://www.usdoj.gov/dea/">www.usdoj.gov/dea/</a></td>
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<td>DHR</td>
<td>Doctors Hospital Renaissance</td>
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<tr>
<td>DIO</td>
<td>Designated Institutional Official</td>
<td></td>
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<tr>
<td>DO</td>
<td>Doctor of Osteopathic Medicine</td>
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<tr>
<td>DPM</td>
<td>Doctor of Podiatric Medicine</td>
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<td>Educational Commission for Foreign Medical Graduates</td>
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<td>FAIMER</td>
<td>Foundation for Advancement of International Medical Education and Research</td>
<td><a href="http://www.faimer.org">www.faimer.org</a></td>
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<td>Federal Credentials Verification Service</td>
<td><a href="http://www.fsmb.org/fcvs_program/cvrhome.htm">www.fsmb.org/fcvs_program/cvrhome.htm</a></td>
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<td>FMG</td>
<td>Foreign Medical Graduate</td>
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<td>IRIS</td>
<td>Intern and Residents Information System</td>
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<td>Joint Commission (formerly known as JCAHO)</td>
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<td>LON</td>
<td>Letter of Notification</td>
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<td>LCME</td>
<td>Liaison Committee on Medical Education</td>
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### Acronyms

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<th>Acronym</th>
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<td>Medical Arts and Research Center</td>
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<td>Medical College Admission Test</td>
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<td>Medical Student</td>
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<td>MHS</td>
<td>Methodist Healthcare System</td>
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<td>Program Information Form (for site visits)</td>
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<td>Training Administrators of Graduate Medical Education</td>
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<td>The Joint Commission</td>
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<td>Texas Medical Board</td>
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<td>United States Medical Licensing Examination</td>
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<td>UTRGV</td>
<td>UT-Rio Grande Valley</td>
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<td>VA</td>
<td>Veteran’s Administration</td>
<td><a href="http://www.southtexas.va.gov">www.southtexas.va.gov</a></td>
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Timeline
General Program Timeline

Monthly Tasks

In general, there are quite a few tasks that should be attended to on a monthly basis. These tasks are listed here and should be added every month to your schedule if applicable to your program’s circumstances. This list may not be inclusive of all that may occur in your program.

- Prepare and distribute monthly schedules (call, clinic, conferences, etc.).
- Ensure residents have meal tickets.

In New Innovations:
- Monitor and track duty hours
- Ensure residents complete their duty hours logging by the first day of the month for the previous month
- Triage duty hours violations to verify they are not due to logging errors. Confirm errors are corrected and comments and causes logged for residents with actual violations
- Ensure that block schedule changes are made in Ni before evaluations are released
- Ensure that no evaluations are missing from sessions before evaluations are released
- Monitor response rates on evaluations

Annual Events

In addition to monthly tasks, there are a few annual events, the timing of which vary from program to program. Annual events listed here may not be inclusive of all that may occur in your program.

- In-training exams
- ACGME Resident Surveys
- ACGME Faculty Surveys
- Check PLA’s for expiration and update every 3 years
- Check Policies requiring GMEC approval for updates every 2 years
- Annual Program Evaluation
- Board application start times and deadlines vary from specialty to specialty. Remind residents to apply at the appropriate time

JULY

July 1 is the beginning of the academic year for most programs. This is the day the majority of new residents and fellows begin their training. In general, when new residents begin, you will want to make sure of the following items (may not be inclusive of all that may occur in your program).
• Residents have faculty advisors
• Vacation schedules are set up, being mindful of conflicts with rotations outside of your program and In-Training Exam dates

New Innovations
• Check every resident’s record to verify he/she advanced properly to the correct status and cumulative PGY level. Review start and end dates of each year in training record
• If you allow residents to progress to independent practice by PGY level, update the Procedure Logger in Ni to indicate which residents can do what procedures without direct supervision (this should be done as close to 7/1 as possible)
• Enter resident pagers, UTHSCSA email addresses, home addresses, paysources and permits/licenses in Ni
• Update resident addresses and phone numbers in Ni
• Begin monitoring/tracking duty hours
• Begin setting up evaluation sessions in Ni for the entire year once block schedules have been entered

GME Track
• “GME Track Resident Census” release date - new residents should be entered into GME Track

ADS
• New residents can be entered in ADS along with rotations and program information

OTHER
• Send out new academic year pager list and photos to all appropriate faculty and staff
• Assist new housestaff in their transition to the program

AUGUST

OTHER
• Periodically throughout the year you should be reviewing your recruiting materials and interview process
• Ensure your program website is updated for the new academic year

ADS
• Some programs are contacted to provide Annual Update to ADS
SEPTEMBER

NRMP
• Around the first of the month, NRMP institution/program registration begins for those programs participating in the Main Match

ERAS
• If you are involved in the Main Match, you may access ERAS
• Residency applications begin to arrive.
• Work out processes and procedures with your Program Director for review and screening of applications.
• Set up any local filters in ERAS

ADS
• Some programs are contacted to provide Annual Update to ADS

OCTOBER

New Innovations
• Fall New Innovations Conference

OTHER
• Continue interview/recruitment process

NOVEMBER

OTHER
• AAMC meeting this month
• Schedule semi-annual resident evaluations. You can do this in Ni, if you wish.
• CCC should be meeting to discuss resident Milestones
• Continue interview/recruitment process
DECEMBER

GME Track
- This month is the final GME Track deadline for both the Program and Resident sections of the survey

ADS
- Some programs are contacted to provide Annual Update to ADS
- Milestones must be entered for every resident

OTHER
- Semi-annual resident reviews
- Continue interview/recruitment process

JANUARY

NRMP
If involved in Main Match,
- Indicate in NRMP if your program will participate in SOAP
- Rank order begins; applicants and programs may start entering their rank order list
- Confirm NRMP quota before deadline at end of month

ADS
- ACGME Resident and Faculty Surveys open for some programs
- Ensure program meets benchmark minimum participation percentage for Resident and Faculty Surveys

OTHER
- Ensure GMEC meetings for the year on all PD's calendars
- Continue interview/recruitment process

FEBRUARY

NRMP
If involved in Main Match,
- Check Applicant Match History for every applicant you plan to rank
• Rank order list certification deadline this month. Must ensure that ROL is confirmed and certified
• Register your programs for ERAS for the following year

New Innovations
  • GME Office will request updated rotation breakdowns

ADS
  • ACGME Resident and Faculty Surveys open for some programs
  • Ensure program meets benchmark minimum participation percentage for Resident and Faculty Surveys

OTHER
  • Many programs hold their chief resident election around this time

MARCH

NRMP
  If involved in Main Match,
  • Match Day is mid-month

ERAS
  • Change starting residents to Will Start status after match week

ADS
  • ACGME Resident and Faculty Surveys open for some programs
  • Ensure program meets benchmark minimum participation percentage for Resident and Faculty Surveys

OTHER
  • Assemble TMB spreadsheet as soon as possible to obtain TMB ID’s for new residents
  • Complete liability spreadsheet for enrollment in UT System
  • Send out Welcome Letter to new residents and fellows
  • Check visa requirements for any international medical graduates joining the program
  • This is a good time to revise recruitment materials for next academic year
  • Distribute information on new housestaff to appropriate rotation sites
  • Send GME Office graduation certificate information
  • ACGME National Meeting
APRIL

New Innovations
- Spring New Innovations Conference

OTHER
- By this time, you should have received TMB #’s for residents. This is about 120 days before July 1st, so you may tell residents they can apply to the TMB for permits
- Schedule program-level new resident orientation
- Incoming resident processing via Onboarding in New Innovations
- Complete UH incoming, departing, renewing, switching forms, switching funding by April 15. Send these to UH and to the VA
- Review/revise evaluation questionnaires
- Review/revise logistics for evaluating other residents on your services
- Review goals and objectives for upcoming year
- Review and update resident manual
- Review and update policies and procedures
- Schedule graduation activities
- Schedule ACGME Competency Sessions with GME Office for next academic year

MAY

New Innovations
- Set up your next academic year according to your block schedule

You may begin the following tasks:
- Put resident pagers, UTHSCSA email addresses, paysources and permits/licenses in Ni. Permits and licenses must be entered into Permit section
- Update resident addresses and phone numbers in Ni
- Enter block schedules
- Begin setting up evaluation sessions in Ni for the entire year if block schedules have been entered

OTHER
- Continue Onboarding
- Follow up on licensure/permits for new residents, renewing, and switching residents
- Prepare to close out ERAS
- Make sure End-of-Year evaluations of trainees are scheduled
• Final evaluations on departing residents; PD completes summative final evaluation using the letter template on GME website
• Encourage all trainees to complete GME’s End-of-Year Survey
• Finalize educational conference schedule for upcoming academic year
• CCC should be meeting to assess resident and fellow Milestones

JUNE

ADS
• Milestones must be entered for every resident

New Innovations
• Enter block schedules for residents. They must be entered by July 1st, preferable for the entire year, but definitely for July
• Let GME Office know about anyone extending training

Departing Residents
• Graduation ceremony or graduation activities for graduating housestaff
• Collect forwarding addresses (for final paychecks and alumni surveys) and department-issued electronics, if applicable
• Departing residents may ask you to print out case logs/procedure logs
• Ensure your departing residents participate in TMA Survey
• Ensure residents follow clearance procedure an complete clearance form

Incoming Residents
• Incoming Resident Orientation
• New residents must do health screening
• Assemble program goals and objectives, policies and procedures, and other program documents for distribution among new residents. Set up distribution using curriculum module in Ni
• Continue Onboarding - Ensure new residents have completed all online training modules
• Send out pager list and photo sheet to all appropriate persons

OTHER
• Ensure your current residents participate in GME’s End-of-Year Survey
• Ensure your residents participate in the VA Survey
• Send new rotation schedule to all faculty, residents, clinics, and staff
• Review your evaluation completion records for the academic year
• Ensure anyone extending has a Permit or License that extends beyond 6/30
Policies
Graduate Medical Education

Policies and Procedures

1. Administration & Organization
   1.1. Statement of Commitment to Graduate Medical Education rev. 1/2017
   1.2. GME Organizational Chart rev. 6/2017
   1.3. Continuation of GME Support in the Event of Disaster rev. 5/2017
   1.4. Responsibilities of the Designated Institutional Official rev. 5/2017
   1.5. Continuity of GME Oversight rev. 5/2017
   1.6. Responsibilities of the GME Committee rev. 5/2017

2. General Policies & Procedures
   2.1. GME General Policies rev. 7/2015
       2.1.1. Fifth Pathway and Checklist rev. 5/2016
       2.1.2. Policy on Resident Application Information and Form rev. 7/2016
   2.2. Essential Abilities Req. for Appointment, Reappointment, Retention, & Certification for GME rev. 5/2017
   2.3. Duration of Appointment, Conditions for Appointment or Reappointment, and Non-Renewal of Resident Contracts rev. 7/2015
   2.4. Restrictive Covenants rev. 5/2017
   2.5. Resident Supervision Policy and Template rev. 2/2015
   2.6. Responsibilities of Residents rev. 7/2016
   2.7. Resident Duty Hours and Extension Request and Program-Specific Policy Template rev. 8/2014
   2.8. Resident Promotion rev. 5/2017
   2.9. Levels of Academic Status in Graduate Medical Education rev. 4/2014
   2.11. Residency Closure/Reduction rev. 2/2015
       2.12.1. Checklist for Entry Non-ACGME Programs
       2.12.2. Non-ACGME Fellowship Information Form
       2.12.3. TMB Application for Non-ACGME Fellowships rev. 5/2017
       2.13. Resident Visas rev. 6/2017
       2.13.1. Form: Request for J-1B Sponsorship rev. 9/2014
       2.13.2. International Travel for Trainees on Visas rev. 7/2016
       2.14. Fellow Visas rev. 6/2017
       2.15. Special Electives rev. 10/2013
   2.16. Process for Establishing a New GME Program rev. 2/2015
       2.16.1. Form: Request to Establish a New GME Program rev. 2/2015
   2.17. Medical Degrees Earned by International Medical Graduates rev. 6/2015
   2.18. Educational Resources – Similar or Competing Programs rev. 1/2017
       2.18.1. Critical Care Programs rev. 1/2017
       2.18.2. Sports Medicine Training Programs rev. 1/2017
       2.18.3. Pain Medicine Programs rev. 1/2017
   2.20. Interactions Between Vendors and GME Programs/Residents rev. 5/2017
   2.20.1. Interactions Between Residents and Physician Recruiters rev. 2/2015
   2.21. Alternative and Innovative Approaches for Programs and Request Template rev. 5/2017
   2.22. Prescription Writing by Residents rev. 7/2015
   2.23. Access to Residents as Research Subjects rev. 7/2015
   2.23.1. Request to Survey Residents Template rev. 7/2016

3. Evaluation and Assessment Processes
   3.1. GMEC Oversight of ACGME-Accredited Programs rev. 6/2017
       3.1.1. Policy for Graduate Medical Education (GMEC) Oversight of non ACGME-Accredited Fellowships rev. 6/2017
   3.2. Resident Evaluation rev. 2/2015
       3.2.1. Templates - Final Summative Evaluation rev. 2/2015
4. Program Policies & Procedures

4.1. Responsibilities of the Residency Program Director rev. 8/2015

4.1.1. Process for Change in Program Director rev. 5/2017

4.1.1.1. Change in PD Form rev. 2/2014

4.2. Application Process

4.2.1.1. Acknowledgement of GME Information Form for Applicants to GME Training at UTHSCSA rev. 7/2016

4.2.2. Security Background and Sanction Checks for Resident Applicants rev. 9/2015

4.3. Resident Selection and Appointment rev. 6/2015

4.3.1. Processing for Accepting Transferring Residents rev. 6/2015

4.3.2. Process for Documentation of Residents Departing from GME Programs at a Non-Standard Time eff. 9/2016

4.4. Visiting Residents

4.4.1. Visiting Residents 1 - Observerships rev. 6/2015

4.4.1.1. Visiting Resident 1 - Observership Application and Checklist rev. 7/2017

4.4.2. Visiting Residents 2 - Clinical Rotations rev. 2/2015

4.4.2.1. Visiting Residents 2 - Clinical Rotation Application and Checklist rev. 5/2016

4.4.3. Visiting Residents 3 - Military Rotators rev. 5/2017

4.4.3.1. Checklist - Military Rotators rev. 5/2017

4.5. Information about Board Eligibility rev. 5/2017

4.6. Responsibilities of the Teaching Faculty rev. 5/2017

4.7. Transition of Care (Hand-Off) eff. 6/2015

4.8. Requesting Increase in Resident/Fellow Complement - form eff. 5/2017

4.9. Responsibilities of Residency Program Administration eff. 9/2016

5. Information Management

5.1. Resident Electronic Mail Accounts at UTHSCSA rev. 5/2017

5.2. Use of Internet and Social Networking Sites rev. 2/2015

6. Fiscal Policies & Procedures

6.1. Resident Compensation rev. 7/2015

6.1.1. Request for Waiver on Resident Compensation Form

6.2. Residents’ Graduate Medical Education Agreements (Contracts) rev. 5/2017

6.3. Compensation and Benefits rev. 6/2014

6.4. Moonlighting by Residents rev. 7/2015

6.4.1. Moonlighting Documentation Form rev. 7/2015

6.4.2. Additional Voluntary Programmatic Duties rev. 7/2015

6.5. Moonlighting by Fellows rev. 7/2015

7. Health & Wellness

7.1. Blood-Borne Pathogen Exposure rev. 5/2017

7.2. Resident Impairment rev. 6/2015

7.3. Family and Medical Leave rev. 3/2017

7.3.1. Information about Impact of Leave on Board Eligibility rev. 5/2017

7.4. Accommodation of Residents with Disabilities rev. 9/2015

7.5. Harassment rev. 5/2016

7.6. Disruptive Behavior by Residents and Fellows rev. 5/2016

7.7. Consensual Relationships

8. Hospitals and Clinical Duties

8.1. Completion of Medical Records rev. 5/2017

8.2. HIPAA - Violation Disciplinary Guidelines for Residents rev. 5/2017

8.3. Disclosure of Adverse Events by Site

8.3.1. UTHSCSA Disclosure to Patients of Unanticipated Outcomes

8.3.2. UHS Communication of Adverse Events

8.3.3. VA Disclosure of Adverse Events

8.3.4. CSR Disclosure of Medical Errors