**NATIONAL BOARD FOR CERTIFICATION**

*Training Administrators of Graduate Medical Education*

**OFFICIAL TAGME ASSESSMENT STUDY GUIDE**
**2023**

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# ACGME
# Common Program Requirements (Residency)

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**Revision Information**
ACGME-approved interim revision: September 17, 2022; effective July 1, 2023

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**Definitions**
For more information, see the ACGME Glossary of Terms.

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.

**Osteopathic Recognition**
For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

## Common Program Requirements (Residency) Contents

<div align="center">**Proposed Common Program Requirements (Residency)**</div>

**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.**

**Note: Review Committees may further specify only where indicated by "The Review Committee may/must further specify."**

**Introduction**

**Int.A.**        **Definition of Graduate Medical Education**

*Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.*

*Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.*

*Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.*

*Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.*

**Int.B.**        **Definition of Specialty**
        **[The Review Committee must further specify]**

**Int.C.** **Length of Educational Program**
**[The Review Committee must further specify]**

**I.** **Oversight**

**I.A.** **Sponsoring Institution**

*The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.*

*When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.*

> **Background and Intent:** Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

**I.A.1.** The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

**I.B.** **Participating Sites**

*A participating site is an organization providing educational experiences or educational assignments/rotations for residents.*

**I.B.1.** The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)
[The Review Committee may specify which other specialties/programs must be present at the primary clinical site]

**I.B.2.** There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

**I.B.2.a)** The PLA must:

**I.B.2.a).(1)** be renewed at least every 10 years; and, (Core)

**I.B.2.a).(2)** be approved by the designated institutional official (DIO). (Core)

I.B.3.      **The program must monitor the clinical learning and working environment at all participating sites. (Core)**

I.B.3.a)      **At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)**

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**Background and Intent:** While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective education and training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.

Suggested elements to be considered in PLAs will be found in the Guide to the Common Program Requirements. These include:
- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

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I.B.4.      **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 ACGME's Accreditation Data System (ADS). (Core) [The Review Committee may further specify]**

I.C.      **Workforce Recruitment and Retention**

     **The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)**

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**Background and Intent:** It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of individuals underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims.

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I.D.      **Resources**

I.D.1.      **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)**

**[The Review Committee must further specify]**

I.D.2.       The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:

I.D.2.a)       access to food while on duty; (Core)

I.D.2.b)       safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

I.D.2.c)       clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)

Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family, as outlined in VI.C.1.c).(1)

I.D.2.d)       security and safety measures appropriate to the participating site; and, (Core)

I.D.2.e)       accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)

I.D.3.       Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

I.E.       Other Learners and Health Care Personnel

The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and

**advanced practice providers, must not negatively impact the appointed residents' education.** (Core)
**[The Review Committee may further specify]**

> Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.

II.     **Personnel**

II.A.            **Program Director**

II.A.1.          There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

II.A.1.a)        The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)

II.A.1.a).(1)    Final approval of the program director resides with the Review Committee. (Core) [Previously II.A.1.b)]
                 [For specialties that require Review Committee approval of the program director, the Review Committee may further specify. This requirement will be deleted for those specialties that do not require Review Committee approval of the program director.]

> Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC.

II.A.1.b)        The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)
                 [The Review Committee may further specify]

> Background and Intent: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.

II.A.2.          The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

[The Review Committee must further specify minimum dedicated time for program administration, and will determine whether program leadership refers to the program director or both the program director and associate/assistant program director(s).]

Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.

The ultimate outcome of graduate medical education is excellence in resident education and patient care.

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the residency program, as defined in II.A.4.-II.A.4.a).(16). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirement II.B.1. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors, core faculty members, and program coordinators to fulfill their program responsibilities effectively.

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

II.A.3.a) must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the

individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

**II.A.3.b)**      **must include current certification in the specialty for which they are the program director by the American Board of _____ or by the American Osteopathic Board of _____, or specialty qualifications that are acceptable to the Review Committee; and, (Core)**
**[The Review Committee may further specify acceptable specialty qualifications or that only ABMS and AOA certification will be considered acceptable]**

**II.A.3.c)**      **must include ongoing clinical activity. (Core)**

Background and Intent: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.

**[The Review Committee may further specify additional program director qualifications]**

**II.A.4.**      **Program Director Responsibilities**

**The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)**

**II.A.4.a)**      **The program director must:**

**II.A.4.a).(1)**      **be a role model of professionalism; (Core)**

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful

discussion is welcome, with the goal of continued improvement of the educational experience.

**II.A.4.a).(2)** design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; [Core]

**Background and Intent:** The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the structural and social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and eliminating health disparities.

**II.A.4.a).(3)** administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; [Core]

**Background and Intent:** The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

**II.A.4.a).(4)** have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; [Core]

**Background and Intent:** The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators may enable the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of residents in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.

**II.A.4.a).(5)** have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; [Core]

**Background and Intent:** The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role

**modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.**

**There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.**

| II.A.4.a).(6) | submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; [Core] |

**Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.**

| II.A.4.a).(7) | provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; [Core] |

| II.A.4.a).(8) | ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; [Core] |

**Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.**

| II.A.4.a).(9) | ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; [Core] |

| II.A.4.a).(9).(a) | Residents must not be required to sign a non-competition guarantee or restrictive covenant. [Core] |

| II.A.4.a).(10) | document verification of education for all residents within 30 days of completion of or departure from the program; and, [Core] |

| II.A.4.a).(11) | provide verification of an individual resident's education upon the resident's request, within 30 days; and [Core] |

**Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who**

have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

**II.A.4.a).(12)**        **provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s).** (Core)
**[This requirement may be omitted at the discretion of the Review Committee]**

**II.B.**        **Faculty**

*Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.*

*Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.*

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment.

**II.B.1.**        **There must be a sufficient number of faculty members with competence to instruct and supervise all residents.** (Core)
**[The Review Committee may further specify]**

**II.B.2.**        **Faculty members must:**

**II.B.2.a)**        **be role models of professionalism;** (Core)

**II.B.2.b)**        **demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care;** (Core)

> Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

II.B.2.c)       demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.d)       administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.e)       regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)

II.B.2.f)       pursue faculty development designed to enhance their skills at least annually: (Core)

> Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

II.B.2.f).(1)       as educators and evaluators; (Detail)

II.B.2.f).(2)       in quality improvement, eliminating health inequities, and patient safety; (Detail)

II.B.2.f).(3)       in fostering their own and their residents' well-being; and, (Detail)

II.B.2.f).(4)       in patient care based on their practice-based learning and improvement efforts. (Detail)

> Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.

[The Review Committee may further specify additional faculty responsibilities]

II.B.3.       Faculty Qualifications

**II.B.3.a)**  Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

[The Review Committee may further specify]

**II.B.3.b)**  Physician faculty members must:

**II.B.3.b).(1)**  have current certification in the specialty by the American Board of \_\_\_\_\_ or the American Osteopathic Board of \_\_\_\_\_, or possess qualifications judged acceptable to the Review Committee. (Core)

[The Review Committee may further specify additional qualifications and/or requirements regarding non-physician faculty members]

**II.B.4.**  Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

> **Background and Intent:** Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring residents, and assessing residents' progress toward achievement of competence in and the autonomous practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

**II.B.4.a)**  Core faculty members must complete the annual ACGME Faculty Survey. (Core)

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]

[The Review Committee may further specify either:
(1) requirements regarding dedicated time and support for core faculty members' non-clinical responsibilities related to resident education and/or administration of the program, or

(2)  requirements regarding the role and responsibilities of core faculty members, inclusive of both clinical and non-clinical activities, and the corresponding time commitment required to meet those responsibilities.] *

[The Review Committee may specify requirements specific to associate program director(s)]

II.C.  **Program Coordinator**

II.C.1.  There must be a program coordinator. (Core)

II.C.2.  The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)
[The Review Committee must further specify minimum dedicated time for the program coordinator]

Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.

Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison and facilitator between the learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of residents.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.

The minimum required dedicated time and support specified in II.C.2.a) is inclusive of activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than

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the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program coordinator, is also addressed in Institutional Requirement II.B.4. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors, core faculty members, and program coordinators to fulfill their program responsibilities effectively.

II.D.  Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)
[The Review Committee may further specify]

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

III.  Resident Appointments

III.A.  Eligibility Requirements

III.A.1.  An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)

III.A.1.a)  graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)

III.A.1.b)  graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core)

III.A.1.b).(1)  holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)

**III.A.1.b).(2)**    holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)

**III.A.2.**    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, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)

**III.A.2.a)**    Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)
[The Review Committee may further specify prerequisite postgraduate clinical education]

> **Background and Intent:** Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

**III.A.3.**    Resident Eligibility Exception

The Review Committee for _____ will allow the following exception to the resident eligibility requirements: (Core)
[Note: A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission. If the specialty-specific Program Requirements define multiple program formats, the Review Committee may permit the exception only for the format(s) that require completion of a prerequisite residency program prior to admission. If this language is not applicable, this section will not appear in the specialty-specific requirements.]

**III.A.3.a)**    An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.-II.A.2., but who does meet all of the following additional qualifications and conditions: (Core)

**III.A.3.a).(1)**    evaluation by the program director and residency selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of this training; and, (Core)

III.A.3.a).(2)  review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)

III.A.3.a).(3)  verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)

III.A.3.b)  Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

III.B.  **Resident Complement**

The program director must not appoint more residents than approved by the Review Committee. (Core)
[The Review Committee may further specify minimum complement numbers]

Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through ADS. Permanent increases require prior approval from the Review Committee and temporary increases may also require approval. Specialty-specific instructions for requesting a complement increase are found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.

III.C.  **Resident Transfers**

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)
[The Review Committee may further specify]

IV.  **Educational Program**

*The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*

*The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*

*It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.*

IV.A.  **Educational Components**

The curriculum must contain the following educational components:

**IV.A.1.**    a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; **(Core)**

**IV.A.2.**    competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; **(Core)**

> **Background and Intent:** The trajectory to autonomous practice is documented by Milestones evaluations. Milestones are considered formative and should be used to identify learning needs. Milestones data may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

**IV.A.3.**    delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; **(Core)**

> **Background and Intent:** These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

**IV.A.4.**    a broad range of structured didactic activities; and, **(Core)**

**IV.A.4.a)**    Residents must be provided with protected time to participate in core didactic activities. **(Core)**

> **Background and Intent:** It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

**IV.A.5.**    formal educational activities that promote patient safety-related goals, tools, and techniques. **(Core)**

**IV.B.**    ACGME Competencies

> **Background and Intent:** The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the

specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.

IV.B.1.      The program must integrate the following ACGME Competencies into the curriculum:

IV.B.1.a)      Professionalism

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.a).(1)      Residents must demonstrate competence in:

IV.B.1.a).(1).(a)      compassion, integrity, and respect for others; (Core)

IV.B.1.a).(1).(b)      responsiveness to patient needs that supersedes self-interest; (Core)

IV.B.1.a).(1).(c)      cultural humility; (Core)

IV.B.1.a).(1).(d)      respect for patient privacy and autonomy; (Core)

IV.B.1.a).(1).(e)      accountability to patients, society, and the profession; (Core)

IV.B.1.a).(1).(f)      respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)

IV.B.1.a).(1).(g)      ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)

IV.B.1.a).(1).(h)      appropriately disclosing and addressing conflict or duality of interest. (Core)

Background and Intent: This includes the recognition that under certain circumstances, the interests of the patient may be best served by transitioning care to another practitioner. Examples include fatigue, conflict or duality of interest, not connecting well with a patient, or when another physician would be better for the situation based on skill set or knowledge base.

IV.B.1.b)      Patient Care and Procedural Skills

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per

capita costs. In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

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| IV.B.1.b).(1) | **Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health.** (Core) **[The Review Committee must further specify]** |
| IV.B.1.b).(2) | **Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.** (Core) **[The Review Committee may further specify]** |
| IV.B.1.c) | **Medical Knowledge** |
| | **Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care.** (Core) **[The Review Committee must further specify]** |
| IV.B.1.d) | **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 lifelong learning.** (Core) |
| IV.B.1.d).(1) | **Residents must demonstrate competence in:** |
| IV.B.1.d).(1).(a) | **identifying strengths, deficiencies, and limits in one's knowledge and expertise;** (Core) |
| IV.B.1.d).(1).(b) | **setting learning and improvement goals;** (Core) |
| IV.B.1.d).(1).(c) | **identifying and performing appropriate learning activities;** (Core) |
| IV.B.1.d).(1).(d) | **systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement;** (Core) |
| IV.B.1.d).(1).(e) | **incorporating feedback and formative evaluation into daily practice; and,** (Core) |

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| **IV.B.1.d).(1).(f)** | **locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems.** (Core) |
| | **[The Review Committee may further specify by adding to the list of sub-competencies]** |
| **IV.B.1.e)** | **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.** (Core) |
| **IV.B.1.e).(1)** | **Residents must demonstrate competence in:** |
| **IV.B.1.e).(1).(a)** | **communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient;** (Core) |
| **IV.B.1.e).(1).(b)** | **communicating effectively with physicians, other health professionals, and health-related agencies;** (Core) |
| **IV.B.1.e).(1).(c)** | **working effectively as a member or leader of a health care team or other professional group;** (Core) |
| **IV.B.1.e).(1).(d)** | **educating patients, patients' families, students, other residents, and other health professionals;** (Core) |
| **IV.B.1.e).(1).(e)** | **acting in a consultative role to other physicians and health professionals;** (Core) |
| **IV.B.1.e).(1).(f)** | **maintaining comprehensive, timely, and legible health care records, if applicable.** (Core) |
| **IV.B.1.e).(2)** | **Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.** (Core) |
| | **[The Review Committee may further specify by adding to the list of sub-competencies]** |
| **IV.B.1.f)** | **Systems-based Practice** |

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

Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.

IV.B.1.f).(1)    Residents must demonstrate competence in:

working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)

IV.B.1.f).(1).(a)    coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)

Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.

IV.B.1.f).(1).(b)    advocating for quality patient care and optimal patient care systems; (Core)

IV.B.1.f).(1).(c)    participating in identifying system errors and implementing potential systems solutions; (Core)

IV.B.1.f).(1).(d)    incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; (Core)

IV.B.1.f).(1).(e)    understanding health care finances and its impact on individual patients' health decisions; and, (Core)

IV.B.1.f).(1).(f)    using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)

IV.B.1.f).(2)    Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)

> **[The Review Committee may further specify by adding to the list of sub-competencies]**

**IV.C.**          **Curriculum Organization and Resident Experiences**

**IV.C.1.**          The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)
**[The Review Committee must further specify]**

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**Background and Intent:** In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.

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**IV.C.2.**          The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)
**[The Review Committee may further specify]**

**[The Review Committee may specify required didactic and clinical experiences]**

**IV.D.**          **Scholarship**

*Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.*

*The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.*

**IV.D.1.**          **Program Responsibilities**

**IV.D.1.a)**          The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

**IV.D.1.b)**     The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)
[The Review Committee may further specify]

**IV.D.1.c)**     The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

**IV.D.2.**     Faculty Scholarly Activity

**IV.D.2.a)**     Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:
(Core)

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed grants
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

**IV.D.2.b)**     The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:
[Review Committee will choose to require either IV.D.2.b).(1) or both IV.D.2.b).(1) and IV.D.2.b).(2)]

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the residents' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

**IV.D.2.b).(1)**     faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars,

service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; **(Outcome)**

**IV.D.2.b).(2)**     peer-reviewed publication. **(Outcome)**

**IV.D.3.**     Resident Scholarly Activity

**IV.D.3.a)**     Residents must participate in scholarship. **(Core)**
[The Review Committee may further specify]

**V.     Evaluation**

**V.A.**     Resident Evaluation

**V.A.1.**     Feedback and Evaluation

> **Background and Intent:** Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.
>
> Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:
> - residents identify their strengths and weaknesses and target areas that need work
> - program directors and faculty members recognize where residents are struggling and address problems immediately
>
> Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.
>
> End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.
>
> Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

**V.A.1.a)**     Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. **(Core)**

> **Background and Intent:** Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

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| **V.A.1.b)** | **Evaluation must be documented at the completion of the assignment.** (Core) |
| **V.A.1.b).(1)** | **For block rotations of greater than three months in duration, evaluation must be documented at least every three months.** (Core) |
| **V.A.1.b).(2)** | **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion.** (Core) |
| **V.A.1.c)** | **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must:** (Core) |
| **V.A.1.c).(1)** | **use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and,** (Core) |
| **V.A.1.c).(2)** | **provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.** (Core) |
| **V.A.1.d)** | **The program director or their designee, with input from the Clinical Competency Committee, must:** |
| **V.A.1.d).(1)** | **meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones;** (Core) |
| **V.A.1.d).(2)** | **assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and,** (Core) |
| **V.A.1.d).(3)** | **develop plans for residents failing to progress, following institutional policies and procedures.** (Core) |

> **Background and Intent:** Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six

months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

**V.A.1.e)**     At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)

**V.A.1.f)**     The evaluations of a resident's performance must be accessible for review by the resident. (Core)

        [The Review Committee may further specify under any requirement in V.A.1.-V.A.1.f)]

**V.A.2.**     Final Evaluation

**V.A.2.a)**     The program director must provide a final evaluation for each resident upon completion of the program. (Core)

**V.A.2.a).(1)**     The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)

**V.A.2.a).(2)**     The final evaluation must:

**V.A.2.a).(2).(a)**     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; (Core)

**V.A.2.a).(2).(b)**     verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)

**V.A.2.a).(2).(c)**     be shared with the resident upon completion of the program. (Core)

**V.A.3.**     A Clinical Competency Committee must be appointed by the program director. (Core)

**V.A.3.a)** At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. [Core]

**V.A.3.a).(1)** Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. [Core]

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Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. Inclusivity is an important consideration in the appointment of Clinical Competency Committee members, allowing for diverse participation to ensure fair evaluation. The program director has final responsibility for resident evaluation and promotion decisions.

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

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**V.A.3.b)** The Clinical Competency Committee must:

**V.A.3.b).(1)** review all resident evaluations at least semi-annually; [Core]

**V.A.3.b).(2)** determine each resident's progress on achievement of the specialty-specific Milestones; and, [Core]

**V.A.3.b).(3)** meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. [Core]

**V.B.** Faculty Evaluation

**V.B.1.** The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. [Core]

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Background and Intent: The program director is responsible for the educational program and all educators. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members

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have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

**V.B.1.a)** This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)

**V.B.1.b)** This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

**V.B.2.** Faculty members must receive feedback on their evaluations at least annually. (Core)

**V.B.3.** Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the residents' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

**V.C.** Program Evaluation and Improvement

**V.C.1.** The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

**V.C.1.a)** The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)

**V.C.1.b)** Program Evaluation Committee responsibilities must include:

**V.C.1.b).(1)**        review of the program's self-determined goals and progress toward meeting them; (Core)

**V.C.1.b).(2)**        guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)

**V.C.1.b).(3)**        review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)

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**Background and Intent:** To achieve its mission and educate and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims. The Program Evaluation Committee advises the program director through program oversight.

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**V.C.1.c)**        The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)

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**Background and Intent:** Other data to be considered for assessment include:
- **Curriculum**
- **ACGME letters of notification, including citations, Areas for Improvement, and comments**
- **Quality and safety of patient care**
- **Aggregate resident and faculty well-being; recruitment and retention; workforce diversity, including graduate medical education staff and other relevant academic community members; engagement in quality improvement and patient safety; and scholarly activity**
- **ACGME Resident and Faculty Survey results**
- **Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance.**
- **Aggregate faculty evaluation and professional development**

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**V.C.1.d)**        The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

**V.C.1.e)**        The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)

**V.C.2.** **The program must complete a Self-Study and submit it to the DIO.**
(Core)

> **Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the Accreditation Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Accreditation Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Accreditation Self-Study are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process is available on the ACGME website.**

***V.C.3.*** ***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.***

***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board. [If certification in the specialty is not offered by the ABMS and/or the AOA, V.C.3.a)-V.C.3.f) will be omitted.]***

**V.C.3.a)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.**
(Outcome)

**V.C.3.b)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.**
(Outcome)

**V.C.3.c)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.**
(Outcome)

**V.C.3.d)** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)

**V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. [Outcome]

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**Background and Intent:** Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

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**V.C.3.f)** Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. [Core]

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**Background and Intent:** It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

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**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*

- *Appreciation for the privilege of caring for patients*

- *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

**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).(2)**      Patient Safety Events

*Reporting, investigation, and follow-up of safety 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).(2).(a)**      Residents, fellows, faculty members, and other clinical staff members must:

**VI.A.1.a).(2).(a).(i)**      know their responsibilities in reporting patient safety eventsuand unsafe conditions at the clinical site, including how to report such events; and, (Core)

**VI.A.1.a).(2).(a).(ii)**      be provided with summary information of their institution's patient safety reports. (Core)

**VI.A.1.a).(2).(b)** Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement 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).(3)** Quality Metrics

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

**VI.A.1.a).(3).(a)** Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)
[The Review Committee may further specify]

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

> **Background and Intent:** Each patient will 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.

**VI.A.2.a).(2)** 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.]

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Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident-patient interactions, education and training locations, and resident skills and abilities, even at the same level of the educational program. The degree of supervision for a resident is expected to evolve progressively as the resident gains more experience, even with the same patient condition or procedure. The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.

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**VI.A.2.b)**        **Levels of Supervision**

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

**VI.A.2.b).(1)**        **Direct Supervision:**

**VI.A.2.b).(1).(a)**        the supervising physician is physically present with the resident during the key portions of the patient interaction; or,
[The Review Committee may further specify]

**VI.A.2.b).(1).(a).(i)**        PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a). (Core)
[The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]

**VI.A.2.b).(1).(b)**        the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
[The RC may choose not to permit this requirement. The Review Committee may further specify]

**VI.A.2.b).(2)**        Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the

resident for guidance and is available to provide appropriate direct supervision.

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

**VI.A.2.c)**        **The program must define when physical presence of a supervising physician is required.** (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)

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**Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.**

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**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 and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

Background and Intent: This requirement emphasizes the professional responsibility of residents and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of residents, faculty members, 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. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and 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 practitioner.

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

**VI.B.2.a)** be accomplished without excessive reliance on residents to fulfill non-physician obligations; (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.b)** ensure manageable patient care responsibilities; and, (Core) [The Review Committee may further specify]

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.2.c)** include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)

**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)

> Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, residents, and faculty.

**VI.B.4.**    Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)

**VI.B.5.**    Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

> Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

**VI.B.6.**    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**

*Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.*

*Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.*

**VI.C.1.**     The responsibility of the program, in partnership with the Sponsoring Institution, must include:

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

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

> 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 safety events.

**VI.C.1.c)**     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. 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.c).(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.d)**     education of residents and faculty members in:

**VI.C.1.d).(1)**     identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)

**VI.C.1.d).(2)**     recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)

**VI.C.1.d).(3)**     access to appropriate tools for self-screening. (Core)

> Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials to create systems for identification of burnout, depression, and substance use

disorders. Materials and more information are available in Learn at ACGME (**https://dl.acgme.org/pages/well-being-tools-resources**).

Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions and may be 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/well-being 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)**    providing 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, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

**VI.C.2.a)**    The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)

**VI.C.2.b)**    These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements.

> **Teammates should assist colleagues in need and equitably reintegrate them upon return.**

**VI.D.** **Fatigue Mitigation**

**VI.D.1.** **Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes.** [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.**
>
> **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.** **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. 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 and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)
[The Review Committee may further specify]

Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

**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-off 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-off process. (Outcome)

**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: 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 terms are used 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.

*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 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.

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.

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

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

Background and Intent: 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 occurs within the context of the 80-hour and the one-day-off-in-seven requirements. 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.b)**        **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.c)**          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. [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. 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: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. **(Detail)**

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

> **Background and Intent:** 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*. **(Detail)**

> **Background and Intent:** Exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. 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. **(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)**

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. (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)

[The Review Committee may further specify under any requirement in VI.F.]

Background and Intent: As noted in VI.F.1., clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This 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.

# Common Program Requirements
## Frequently Asked Questions
### ACGME
Numbering issue corrected 8/25/2022

| Question | Answer |
|---|---|
| **Institutions** | |
| What is the purpose of Program Letters of Agreement (PLAs)?<br><br>*[Common Program Requirement: I.B.2.]* | PLAs provide details on faculty, supervision, evaluation, educational content, length of assignment, and policies and procedures for each required assignment that occurs outside of an accredited program's Sponsoring Institution. These documents are intended to protect the program's residents/fellows by ensuring an appropriate educational experience under adequate supervision. For more detailed information and guidance, see the Program Directors' Guide to the Common Program Requirements. |
| What is the minimum experience for which a PLA needs to exist between an accredited program and a site involved in residency/fellowship education?<br><br>*[Common Program Requirement: I.B.2.]* | There must be PLAs between an accredited program and all sites to which residents/fellows rotate for required education or assignments. |
| Are PLAs necessary for "courses," such as the Armed Forces Institute of Pathology course or the Bellevue Hospital Toxicology Course?<br><br>*[Common Program Requirement: I.B.2.]* | These types of courses are not examples of participating sites, and therefore do not require PLAs. |

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| Are PLAs needed when sites are closely associated? For instance, would PLAs be necessary between a university hospital and the children's hospital with which it has close ties?<br><br>*[Common Program Requirement: I.B.2.]* | A program sponsored by a university hospital that requires a rotation/assignment at the children's hospital would require a PLA if the two entities are operated by two different governing bodies (e.g., two separate Boards of Directors). However, if the two sites operate essentially as one entity, that is, they are governed by one governing body (e.g., a single Board of Directors), a PLA is not necessary. This reasoning applies to all closely associated sites, not only those between university and children's hospitals.<br><br>A PLA is not required for a rotation to an integrated site if the written document between the sponsor and the integrated site incorporates the elements of the PLA [Common Program Requirements I.B.1.a)-d)]. Including all the required elements in the Integration Agreement will eliminate the need for a separate PLA. |
| Are PLAs necessary for rotations to physicians' offices, nursing homes, ambulatory surgical centers, and other similar learning environments?<br><br>*[Common Program Requirement: I.B.2.]* | PLAs are not necessary if the following on- or off-campus site is under the governance of the program's Sponsoring Institution or is an office of a physician who is a member of that Sponsoring Institution's teaching faculty/medical staff: nursing and assisted living homes; hospice facilities; faculty members' patient care offices; private physicians' offices (volunteer faculty members); ambulatory surgical centers; diagnostic centers (e.g., imaging, laboratory, etc.); treatment centers (e.g., dialysis, rehabilitation, chemotherapy, etc.); or other similar sites.<br><br>PLAs *are* required for rotations to these types of sites if not governed by the program's Sponsoring Institution or if they occur in offices of physicians who are not members of the Sponsoring Institution's teaching faculty/medical staff. Some Review Committees have more stringent criteria, so program directors should consult and review the specialty-/subspecialty-specific Program Requirements and the specialty section of the ACGME website for more details, when applicable. |

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| If a program director and/or faculty member functions within multiple participating sites that educate residents/fellows (e.g., the program director oversees the program at the sponsoring university hospital and is also the local director at the VA medical center), is a PLA required with the program director and/or faculty member?<br><br>*[Common Program Requirement: I.B.2.]* | PLAs are not necessary when a rotation/assignment occurs at a site under the governance of the program's Sponsoring Institution or in an office of a physician who is a member of the Sponsoring Institution's teaching faculty/medical staff. However, in this example, the VA is unlikely to be under the governance of the Sponsoring Institution, so the program director needs to appoint a local director at the VA site who is accountable for the day-to-day activities of residents/fellows [Common Program Requirement II.A.4.b)]. A PLA between the program director and the local director would be necessary in this example. |
| Who should sign the PLAs for the Sponsoring Institution and for the participating sites?<br><br>*[Common Program Requirement: I.B.2.]* | A PLA should include the signatures of the program director as initiating the letter and the local director at the participating site. The official signing for the participating site to which the residents/fellows rotate should be the individual responsible for supervising and overseeing resident/fellow education at that location (e.g., the local director or, in some cases, the medical director). Although the requirements do not specify that the PLA include the signature of the designated institutional official (DIO), institutions may find it prudent to include this signature. It is the responsibility of the DIO, in collaboration with the Graduate Medical Education Committee (GMEC) of the Sponsoring Institution, to establish and administer the local policies and procedures regarding PLAs. |
| Does a subspecialty program need a separate PLA if a specialty program already has one in place with a particular institution?<br><br>*[Common Program Requirement: I.B.2.]* | Although a single PLA that provides the Review Committee with appropriate information (i.e., the content of the experience, supervision, evaluation, length of assignment, policies and procedures) for both the specialty and subspecialty programs would be acceptable, such a document may be long and overly complicated. The preferred strategy would be to develop two separate letters, one for the specialty program, and another for the subspecialty program. |
| When should PLAs be updated?<br><br>*[Common Program Requirement: I.B.2.]* | Agreements should be updated whenever there are changes in program director or participating site director or in resident/fellow assignments, or when there are revisions to the items specified in Common Program Requirements I.B.1.a)-d). PLAs must be renewed at least every 10 years. If nothing in the agreement has changed at the end of ten years, it is acceptable to add an amendment signifying review and extension of the agreement with signatures. |

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| How are PLAs reviewed for purposes of accreditation?<br><br>*[Common Program Requirement: I.B.2.]* | Program directors should have the PLAs available for review by the Accreditation Field Representative during a program site visit. Program directors and DIOs should contact the Review Committee Executive Director for more specific details or further clarification. |
| Is a Sponsoring Institution required to maintain master affiliation agreements with its major participating sites?<br><br>*[Common Program Requirement: I.B.2.]* | No; the Institutional Requirements (effective since July 1, 2014, including the most recent revision, effective July 1, 2022) no longer require Sponsoring Institutions to maintain master affiliation agreements with their major participating sites. |
| **Personnel** | |
| Are there circumstances in which a Sponsoring Institution, in partnership with its programs, is required to provide support and dedicated time that exceeds the minimum specified in the requirements?<br><br>*[Common Program Requirements: II.A.2. and II.C.2.]* | The dedicated time and support requirements for ACGME activities specified in II.A.2. and II.A.2.a) for program leadership, II.C.2. and II.C.2.a) for program coordinators, and section II.B.4. for those specialties that specify a minimum level of support for core faculty members, are minimum requirements, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirements II.B.-II.B.4. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors, core faculty members, and program coordinators to fulfill their program responsibilities effectively.  If the Institutional Review Committee determines that support and dedicated time for one or more programs within a Sponsoring Institution is inadequate, it may issue a citation even if the minimum specified in the applicable specialty/subspecialty-specific Program Requirements has been met. |
| **Resident/Fellow Appointments** | |

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| For entry into ACGME-accredited residency programs in specialties that do not require an initial year prior to entry, can residents receive any credit for education and training completed in programs not accredited by the ACGME, the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC)?<br><br>*[Common Program Requirement, Residency version: III.A.3.)]* | In specialties that do not require an initial year prior to entry into a program, a credit for one year of education and training may be allowed, at the program director's discretion, for residents who have completed a residency program, in the same specialty, not accredited by the ACGME, RCPSC, or CFPC. Such residents must enter at the PGY-1 level and may be advanced to the PGY-2 level by the Clinical Competency Committee (CCC) based on Milestones assessments.<br><br>The Review Committees do not review or approve this credit for prior education and training on a per-resident basis. The appropriate American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board should be contacted to determine if a resident will receive credit for prior education and training. |
| To what does "…a residency program that was not accredited by the ACGME, RCPSC, or CFPC, or a residency program with ACGME-I Advanced Specialty accreditation…" refer?<br><br>*[Common Program Requirement, Residency version: III.A.3.)]* | An example is completion of an international residency not accredited by ACGME International (ACGME-I). Individuals who have completed such education and training are eligible for admission to an ACGME-accredited program at the PGY-1 level and advancement to the PGY-2 level based on Milestones assessments. Note that this applies only to programs in specialties for which an initial clinical year is not required for entry. |

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| Are individuals who have completed residency programs not accredited by one of the organizations specified in III.A.2. eligible for appointment to an ACGME-accredited residency program that requires completion of a residency as a prerequisite for entry?<br><br>*[Common Program Requirements, Residency version: III.A.2) and III.A.3)]* | Review Committees may grant the exception specified in III.A.4. of the Program Requirements for specialties that require completion of another prerequisite residency program prior to admission. Note this applies only to programs in specialties for which an initial clinical year is not required for entry.<br><br>The Review Committees for Allergy and Immunology, Nuclear Medicine, and Plastic Surgery may grant the exception specified in III.A.4. of the Program Requirements for residency programs that require completion of another prerequisite residency program prior to admission.<br><br>The Review Committees for Colon and Rectal Surgery and Thoracic Surgery will not permit this exception.<br><br>Nuclear medicine programs accept residents at the NM1 (second post-graduate year) after completion of a clinical base year, at the NM2 level after completion of a residency program in another specialty, and at the NM3 level after completion of a radiology residency. Applicants entering at the NM1 level would need to complete a clinical base year in a program accredited by the ACGME, RCPSC, CFPC, or in a program with ACGME-I Advanced Specialty Accreditation. Applicants who have completed a residency program in diagnostic radiology or another specialty not accredited by one of the organizations referenced above could apply for entry at the NM2 or NM3 level respectively per III.A.2.b). |
| Are individuals who have completed a combined residency program not accredited by the ACGME eligible for appointment to an ACGME-accredited fellowship program?<br><br>*[Common Program Requirement Fellowship and One-Year Fellowship Versions: III.A.1.]* | Examples of such programs include emergency medicine-pediatrics, family medicine-preventive medicine, and psychiatry-pediatrics-child psychiatry. The ACGME website now lists these programs as "Combined Specialty Tracks – components individually accredited." If each of the programs participating in the combined programs is ACGME-accredited, residents enrolled in the combined program are eligible for transfer into another ACGME-accredited residency program and graduates of the program are eligible for appointment to an ACGME-accredited fellowship. While the ACGME does not accredit combined programs (with the exception of internal medicine-pediatrics), it does accredit each of the programs constituting the combined program. Therefore, graduates of these programs have completed their education and training in ACGME-accredited residency programs. |

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| If a fellowship program is unable to obtain Milestones assessments from the residency program of a fellow entering in a given year, will the program be cited for failing to obtain this information?<br><br>*[Common Program Requirement, Residency version: III.A.2.a); Common Program Requirement, Fellowship and One-Year Fellowship versions: III.A.1.]* | If a program is able to document that the Milestones assessments were requested from the residency program director, the fellowship program will not be cited for non-compliance even if the residency program director does not provide the assessments. A new reporting feature is now available for fellowship programs within the Accreditation Data System (ADS) to provide fellowship program directors access to the final Milestones report for an active fellow's most recently completed residency program.<br><br>There are a few scenarios in which these reports may not be available, such as if the resident completed residency in a program not accredited by the ACGME, if the resident completed residency prior to the Milestones implementation, or if the resident's previous experience could not be matched when entered into the program. For those without Milestones reports, programs must contact the specialty program director from the fellow's most recent residency program to obtain the required information.<br><br>This new reporting feature can be found in ADS by logging in and navigating to the program's "Reports" tab, and then selecting the "Residency Milestone Retrieval" option. |

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| Why does the ACGME require the GMEC or a subcommittee of the GMEC to review and approve all candidates under the "exceptionally qualified applicant" exception?<br><br>*[Common Program Requirement, Residency version: III.A.4.a).(2); Common Program Requirement, Fellowship and One-Year Fellowship versions: III.A.1.c).(1).(b)]* | The requirement that the GMEC or a subcommittee of the GMEC review and approve all candidates under the "exceptionally qualified applicant" exception is to provide a check on candidates qualifying under the definition of this exception. A graduate medical education program is an educational program associated with health care providers that assume a continued presence of a particular number of residents/fellows at a particular knowledge, skill, and competence level, who both treat patients under physician supervision, and supervise more junior learners. A gap in the number of qualified fellows may be disruptive to the normal provision of health care. In these circumstances, program directors may perceive pressure from individuals within an institution to fill empty slots for the sake of avoiding the disruption, but with less attention to a particular candidate's knowledge, skill, and competence level.<br><br>The Review Committee sets the requirements and the program determines if a candidate meets the stated criteria. Because the Review Committee does not review or approve the determination of an exceptionally qualified applicant, the ACGME relies on the Sponsoring Institution to provide oversight in the selection of exceptional candidates and monitoring of their performance. This oversight promotes programs' exercise of due diligence in selection. The oversight need not be burdensome or intrusive; rather it provides an opportunity for the GMEC to collaborate with programs to ensure that these select candidates fulfill expectations for entry-level competence. |
| **Educational Program** | |
| What are the ACGME's expectations regarding rotational transitions of care, and how should programs and institutions establish effective curriculum to minimize the risks surrounding such transitions and improve supervisory continuity?<br><br>*[Common Program Requirement: IV.C.1.]* | Transitions of care, specifically those occurring at the end of a rotation or service, are associated with worse patient outcomes, disruptions in patient care, increased resident/fellow anxiety, and increased stress on other health care staff members. The process for these transitions is often not standardized at most institutions. While the ACGME recognizes a lack of evidenced-based best practices to address and ameliorate this discontinuity, Sponsoring Institutions and programs are expected to have a documented process by which these rotational transitions are managed at each site. Communication about patient care, the clinical learning environment, and the supervisor roles, should be standardized among residents/fellows rotating in each specific clinical learning environment. For example, rotational transitions should follow the same format for all residents transitioning service on general wards while the format of these transitions may differ for residents rotating in an ICU environment. Although the format of communication may differ for each separate type of clinical learning environment to address the individual rotation's communication needs, programs are expected to outline a |

| | standardized process to ensure continuity for each rotation. Models used in daily-type transitions, such as SBAR and others, may be useful in guiding the development of standardized processes for rotational-type transitions. |
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| **Evaluation** | |
| What is the role of the program director on the CCC?<br><br>*[Common Program Requirement: V.A.3.]* | The requirements regarding the CCC do not preclude or limit a program director's participation on the committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances. Still, a program should consider: its program director's other roles as resident/fellow advocate, advisor, and confidante; the impact of the program director's presence on the other CCC members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for the program's evaluation and promotion decisions. |
| How can small programs have three members of the program faculty on the CCC?<br><br>*[Common Program Requirement: V.A.3.a)]* | The intent is to have enough members to broaden the input on each resident's/fellow's evaluation. Program faculty representation can include more than physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents/fellows. For example, a fellowship may include faculty members from the affiliated residency program or from required rotations in other specialties. |
| Are non-physicians permitted to serve on the CCC?<br><br>*[Common Program Requirement, Residency version and Postdoctoral Education versions: V.A.3.a).(1) Common Program Requirements Fellowship and One-Year Fellowship versions: V.A.3.]* | The requirements are intended to provide the program director with sufficient flexibility to select individuals who have the background and experience needed to evaluate resident/fellow performance based on the Milestones. This may include health professionals who have extensive contact and experience with the program's residents/fellows, such as, but not limited to, nurses, PhDs, physicians' assistants, and therapists. |
| What is the role of the program coordinator on the CCC?<br><br>*[Common Program Requirement: V.A.3]* | Program coordinators play a critical role in their programs and may, through the program's resident/fellow evaluation system, provide valuable insight on resident/fellow performance in areas such as interpersonal and communication skills, teamwork, and professionalism. Further, the program coordinator may, at the program director's discretion, attend CCC meetings to support the activities of the CCC, such as collation of data on each resident/fellow, taking meeting minutes, recording decisions, and managing the submission of Milestones data to the ACGME. However, evaluation of resident/fellow competence related to the Milestones for patient care and medical knowledge is a vital responsibility of the CCC and these assessments should be made by individuals with background and experience in health care. Therefore, program coordinators, although they may |

| | administratively support the committee and take part in the 360 assessments of the residents/fellows, may not serve as voting members of the CCC. |
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| What role can program residents, including chief residents who have not completed the program, play on the CCC?<br><br>*[Common Program Requirement: V.A.3.a)]* | Program residents and chief residents in accredited years of the program may provide input to the CCC Chair and/or the program director, outside the context of CCC meetings, through the evaluation system. However, to ensure that residents' peers are not involved in promotion and graduation decisions, and that they are not involved in recommendations for remediation or disciplinary actions, these residents may not serve as CCC members or attend CCC meetings. |
| Are there any circumstances when would it be acceptable for the Program Evaluation Committee (PEC) to not include a resident/fellow member?<br><br>*[Common Program Requirement: V.C.1.a)]* | A resident/fellow must always be included on a PEC unless there are no residents/fellows enrolled in the program. The PEC must meet annually, even when there are no residents/fellows enrolled in the program, to evaluate and review the program. |
| **The Learning and Working Environment** | |
| Does the ACGME require electronic, "real-time" monitoring of clinical and educational work hours for all accredited programs?<br><br>*[Common Program Requirement: VI.F.1.); Institutional Requirement: IV.K.]* | The ACGME requires that Sponsoring Institutions and programs monitor residents'/fellows' clinical and educational work hours to ensure they comply with the requirements, but does not specify how monitoring and tracking of clinical and educational work hours should be accomplished. The ACGME does not mandate a specific monitoring approach since the ideal approach should be tailored to each program and its Sponsoring Institution. For example, the approach best suited for a neurological surgery program will be different from what is most appropriate for preventive medicine, dermatology, or pediatrics programs. |
| The philosophical statement in the Introduction to Section VI references effacement of self-interest as a component of professionalism. Isn't this in conflict with the emphasis on physician well-being reflected in the new requirements?<br><br>*[Common Program Requirement: VI. Introduction]* | Effacement of self-interest is an essential component of professionalism for physicians but does not imply that physicians should jeopardize their own well-being to prioritize the well-being of their patients. Prioritization of physician well-being is important in ensuring that physicians remain fit to provide care for their patients. Requirement VI.C.2. requires a process to ensure continuity of care if residents or fellows are unable to perform their patient care duties, and Requirement VI.B.5. addresses the expectation that residents/fellows and faculty members demonstrate responsiveness to patient needs that supersedes self-interest and emphasizes that in some circumstances, the best interests of the patient may be served by transitioning the patient's care to another qualified and rested provider. |

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| Are the requirements related to patient safety and quality improvement intended to apply solely in inpatient settings?<br><br>*[Common Program Requirement: Section VI.A.1.]* | The requirements related to patient safety and quality improvement are not limited to inpatient experiences, and are inclusive of care provided in outpatient settings. |
| With regards to the requirement relating to provision of data to residents/fellows and faculty members on quality metrics and benchmarks related to their patient populations, is the expectation that individual data regarding clinical performance must be provided?<br><br>*[Common Program Requirement: VI.A.1.b).(2).(a)]* | Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the Sponsoring Institution are shared with residents/fellows and faculty members. Examples of metrics include, but are not limited to, those provided by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Centers for Medicaid and Medicare Services (CMS), Press Gainey, and National Surgical Quality Improvement Program (NSQIP). |
| How should the appropriate level of supervision be determined for each resident or fellow?<br><br>*[Common Program Requirements: VI.A.2.c)-VI.A.2.c).(3)]* | The assignment of progressive responsibility for patient care to residents and fellows is an essential component of graduate medical education and is necessary to prepare residents and fellows to be independent practitioners. While decisions regarding the appropriate level of supervision are made by the program director and faculty members, the Common Program Requirements provide a framework for the progression from direct supervision to oversight. The program director determines the level of supervision required for an individual resident or fellow both by assessing the abilities and competence of the resident/fellow and the needs of the individual patient. Therefore, the level of supervision required for a resident or fellow may vary based on the circumstances. |
| How can residents and fellows identify the accountable attending physician for each patient for whom they are providing care?<br><br>*[Common Program Requirement: VI.A.2.a).(1)]* | Residents and fellows must know who the accountable attending physician is prior to making any clinical decisions on behalf of a patient. The program and institution are responsible for providing that information to all residents and fellows. Residents and fellows are responsible for keeping the accountable physician informed. |

| How should residents communicate with the accountable physician?<br><br>*[Common Program Requirement: VI.A.2.a).(1)]* | This communication may occur in-person or via portal, fax, text, phone, or email. It is essential that each patient's primary physician be listed in the patient's chart. If that information is not in the chart, the patient should be asked to provide the name of their primary physician. If the patient does not have one, a determination regarding who will assume responsibility for overall care must be made and documented in the patient's chart. |
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| How will compliance with the requirement regarding accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data be assessed?<br><br>*[Common Program Requirement: VI.B.4.f)]* | Approaches for monitoring and documenting are left to the discretion of program and institutional leaders, who should decide on the optimal way to ensure accuracy of reporting. |

| What is work compression and why is it addressed in the requirements?<br><br>*[Common Program Requirement: VI.C.1.b)]* | Work compression occurs when physicians are required to do the same amount of work in less time, and is addressed in the Common Program Requirements to ensure that programs consider the impact of work compression on well-being and how the impact can be minimized. To help frame the issue, a review of relevant literature is provided below.<br><br>Research has found high workload and work compression associated with reduced empathy in medical interns (Bellini, 2002), with residents selectively discharging older inpatients earlier (Hilson, 1993), with increased risk for mortality (Hilson, 1992, Ong 2007) and readmission (Thanarajasingam, 2012), lower patient satisfaction (Griffith, 1998), greater use of diagnostic tests (Griffith, 1996), and shifting from active patient care to monitoring to keep workload manageable (Cao, 2008). Studies of the effect of workload on resident outcomes found reduced educational participation with higher workload (Arora, 2008), an inverse relationship between workload and intern perceptions of the quality of their education and their own professionalism (Auger, 2012), and improved conference attendance with a limit on patient admissions (Thanarajasingam, 2012).<br><br>Bellini LM, Baime M, Shea JA. 2002. Variation of mood and empathy during internship. *JAMA* 287:3143–46<br>Hilson SD, Rich EC, Dowd BE, et al. 1993. The impact of intern workload on length of hospital stay for elderly patients. *Gerontol. Geriatr. Educ.* 14(2):33–40<br>Hillson SD, Rich EC, Dowd B, et al. 1992. Call nights and patients care: effects on inpatients at one teaching hospital. *J. Gen. Intern. Med.* 7(4):405–10<br>Ong M, Bostrom A, Vidyarthi A, et al. 2007. House staff team workload and organization effects on patient outcomes in an academic general internal medicine inpatient service. *Arch. Intern. Med.* 167(1):47–52<br>Thanarajasingam U, McDonald FS, Halvorsen AJ, et al. 2012. Service census caps and unit-based admissions: resident workload, conference attendance, duty hour compliance, and patient safety. *Mayo Clin. Proc.* 87(4):320–27<br>Griffith CH 3rd, Wilson JF, Rich EC. 1998. The effect at one teaching hospital of interns' workloads on the satisfaction of their patients. *Acad. Med.* 73(4):427–29<br>Griffith CH 3rd, Desai NS, Wilson JF, et al. 1996. Housestaff experience, workload, and test ordering in a neonatal intensive care unit. *Acad. Med.* 71(10):1106–8<br>Cao CG, Weinger MB, Slagle J, et al. 2008. Differences in day and night shift clinical performance in anesthesiology. *Hum. Factors* 50(2):276–90 |

| | Arora VM, Georgitis E, Siddique J, et al. 2008. Association of on-call workload of medical interns with sleep duration, shift duration, and participation in educational activities. *JAMA* 300(10):1146–53<br>Auger KA, Landrigan CP, Gonzalez del Rey JA, et al. 2012. Better rested, but more stressed? Evidence of the effects of resident work hour restrictions. *Acad Pediatr*. Jul-Aug;12(4):335-43 |
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| Can residents/fellows be required to use vacation or sick time when attending appointments during scheduled working hours?<br><br>*[Common Program Requirement: VI.C.1.d).(1)]* | The requirements do not specify whether residents/fellows will be required to use vacation or sick time for medical, dental, and mental health appointments. Programs should comply with their institution's policies regarding time off for such appointments. |
| Can residents/fellows be encouraged to schedule medical, mental health, and dental care appointments on days they are not assigned call?<br><br>*[Common Program Requirement: VI.C.1.d).(1)]* | The intent of this requirement is to ensure that residents and fellows are able to attend appointments as needed, and that their work schedule not prevent them from seeking care when they need it, including during scheduled call days. Programs must not place restrictions on when residents and fellows may schedule these appointments, nor place pressure on them to schedule appointments on days when they are not assigned call. |
| How can programs located in areas where 24/7 in-person access to mental health professionals is not possible comply with this requirement?<br><br>*[Common Program Requirement: VI.C.1.e).(3)]* | The requirement is intended to ensure that residents and fellows 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. Access to a psychiatrist or other mental health professional in the Emergency Department satisfies the expectation for 24/7 access to emergency care. In addition, telemedicine, or telephonic means may be used to satisfy this requirement. |

| What are the ACGME's expectations regarding transitions of care, and how should programs and institutions monitor effective transitions of care and minimize the number of such transitions?<br><br>*[Common Program Requirement: VI.E.3.]* | Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for the specific patient or group of patients. Sponsoring Institutions and programs are expected to have a documented process in place for ensuring the effectiveness of transitions. Scheduling of on-call assignments should be optimized to ensure a minimal number of transitions, and there should be documentation of the process involved in arriving at the final schedule. Specific schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident/fellow education. |
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| How do the ACGME common clinical and educational work hour requirements apply to research activities?<br><br>*[Common Program Requirement: VI.F.]* | The clinical and educational work hour requirements pertain to all required hours in the program (the only exceptions are reading and self-learning). When research is a formal part of the residency/fellowship and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent clinical and educational work hour requirements.<br><br>When programs offer an additional research year that is not part of the accredited years, or when residents/fellows conduct research on their own time, making these hours identical to other personal pursuits, these hours do not count toward the limit on clinical and educational work hours. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident/fellow when the resident/fellow participates in patient care.<br><br>Some programs have added clinical activities to "pure" research rotations, such as having research residents/fellows cover "night float." This combination of research and clinical assignments could result in hours that exceed the weekly limit and could also seriously undermine the goals of the research rotation. Review Committees have traditionally been concerned that required research not be diluted by combining it with significant patient care assignments. |

| Is there a provision for training pathways with alternative schedules to accommodate the needs of those with the ability to become excellent physicians but an inability to take on the demanding usual schedule described in the requirements? *[Common Program Requirement: VI.F.]* | There is nothing in the requirements that prevents a program from providing an alternate pathway based on the needs of individuals, as long as the pathway adheres to other relevant dimensions of the requirements, including the maximums specified for clinical experience and education. |
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| What is included in the definition of clinical and educational work hours under the requirement limiting them to 80 hours per week? *[Common Program Requirement: VI.F.1.]* | 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, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents'/fellows' participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours. Time residents and fellows devote to military commitments counts toward the 80-hour limit only if that time is spent providing patient care. |
| If some of a program's residents/fellows attend a conference that requires travel, how should the hours be counted for clinical and educational work hour compliance? *[Common Program Requirement: VI.F.1.]* | If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements. |

| What are the expectations in terms of a program structure that balances resident/fellow educational opportunities with opportunities for rest and personal well-being?<br><br>*[Common Program Requirement: VI.F.2.a)]* | The intent of the requirement is to ensure that programs recognize the need to balance educational experiences with time away from the program. If an imbalance exists, it is expected that it would be manifest in other aspects of the learning environment, requiring the program to make adjustments as needed. |
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| What is meant by "should have eight hours off"?<br><br>*[Common Program Requirements: VI.F.2.b)-VI.F.2.b).(1)]* | While it is expected that residents' and fellows' schedules will be structured to ensure they are provided with a minimum of eight hours off between scheduled work periods, it is recognized that individual residents or fellows 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 the resident or fellow 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.<br><br>It is important to remember that when an abbreviated rest period is offered under special circumstances, the program director and faculty members must monitor residents/fellows for signs of excessive fatigue. |
| If a post-call resident/fellow remains on site for up to four additional hours as described in the requirements, does the required 14-hour time-off period begin at the end of the scheduled 24-hour period, or when the resident/fellow leaves the hospital?<br><br>*[Common Program Requirements: VI.F.2.c), VI.F.3.a).(1)]* | The 14-hour time-off period begins when the resident/fellow leaves the hospital, regardless of when the resident/fellow was scheduled to leave. |

| Since the requirements state that residents/fellows must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period, how should programs interpret this requirement if the "day off" occurs after a resident's/fellow's on-call day?<br><br>*[Common Program Requirement: VI.F.2.d)]* | The requirements specify a 24-hour day off. Many Review Committees have recommended that this day should ideally be a calendar day (i.e., the resident/fellow wakes up at home and has a whole day available). Review Committees have also noted that it is not permissible to have the day off regularly or frequently scheduled on a resident's/fellow's post-call day, but understand that in smaller programs this may occasionally be necessary. Note that in this case, a resident/fellow would need to leave the hospital post-call early enough to allow for 24 hours off from clinical and educational work. Because call from home does not require a rest period, the day after home call may be used as a day off. |
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| What activities are permitted during the four hours allowed for activities related to patient safety and/or resident/fellow education?<br><br>*[Common Program Requirements: VI.F.3.a).(1)-VI.F.3.a).(1).(a)]* | Residents/fellows who have completed a 24-hour clinical and educational work period may spend up to an additional four hours on site to ensure an appropriate, effective, and safe transition of care (including rounds), to maintain continuity of patient care, and to participate in educational activities such as conferences. During this four-hour period, residents/fellows must not be permitted to participate in the care of new patients in any patient care setting; must not be assigned to outpatient clinics, including continuity clinics; and must not be assigned to participate in a new procedure, such as an elective scheduled surgery. Residents/fellows who have satisfactorily completed the transition of care may attend an educational conference that occurs during this four-hour period. |
| Can clinical and educational work hours for surgical chief residents be extended to 88 hours per week?<br><br>*[Common Program Requirements: VI.F.4.c)-VI.F.4.c).(2)]* | Programs interested in extending the clinical and educational work hours for specific rotations for their chief residents can use the "88-hour exception" to request an increase of up to 10 percent in clinical and educational work hours on a program-by-program basis, with endorsement of the Sponsoring Institution's GMEC and the approval of the Review Committee. If approved, the exception will be reviewed annually by the Review Committee.<br><br>A request for an exception must be based on a sound educational justification. Most Review Committees categorically do not permit programs to use the 10 percent exception. The Review Committee for Neurological Surgery is currently the only Review Committee that allows exceptions. |

| What qualifies as a "sound educational justification" for a rotation-specific increase in the weekly clinical and educational work hour limit by up to 10 percent?<br><br>*[Common Program Requirements: VI.F.4.c)-VI.F.4.c).(2)]* | The ACGME specifies that a rotation-specific increase in clinical and educational work hours above 80 hours per week can be granted only when there is a very high likelihood that this will improve residents'/fellows' educational experiences. This requires that all hours in the extended work week contribute to resident/fellow education.<br><br>Programs may ask for an extension that is less than the maximum of eight additional weekly hours, and/or for a subgroup of the residents/fellows in the program. |
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| In addition to the 80-hour maximum weekly limit, do all other clinical and educational work hour rules apply to moonlighting (maximum clinical and educational work period length, minimum time off between shifts, etc.)?<br><br>*[Common Program Requirements: VI.F.5.a)-c)]* | The hours spent moonlighting are counted toward the total hours worked for the week. No other clinical and educational work hour requirements apply, but the following requirements do:<br><br>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."<br><br>VI.B.3.-VI.B.4.c).(2) "The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding of their personal role in the: provision of patient- and family-centered care; safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; assurance of their fitness for work, including: management of their time before, during, and after clinical assignments; and, recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team." |
| How many times in a row can a resident/fellow take call every other night?<br><br>*[Common Program Requirement: VI.F.7.]* | The objectives for allowing the averaging of in-house call (in all specialties except internal medicine) is to offer flexibility in scheduling, not to permit call every other night for any extended length of time, even if done in the interest of creating longer periods of free time on weekends or later in the month. For example, it is not permissible for a resident/fellow to be on call every other night for two weeks straight and then be off for two weeks. |

| Is it permissible for residents/fellows to take call from home for extended periods, such as a month?<br><br>*[Common Program Requirement: VI.F.8.a)]* | No. The requirement for one day free every week prohibits being assigned home call for an entire month. Assignment of a partial month (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workload and intensity of in-house activities. |
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| Can PGY-1 residents take at-home call, and if so, what are the work hour restrictions for this?<br><br>*[Common Program Requirement, Residency version: VI.A.2.c).(1).(a).(i)]* | PGY-1 residents are not initially allowed to take at-home call because appropriate supervision (either direct supervision or indirect supervision with direct supervision immediately available) is not possible when a resident is on at-home call. However, a Review Committee may specify the circumstances and achieved competencies required for residents to progress to be supervised indirectly with direct supervision available at some point after the beginning and before the end of the PGY-1. Program directors should review the specialty-specific requirements for further clarification. |
| Why do the requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks?<br><br>*[Common Program Requirement: VI.F.1.]* | The requirements acknowledge the changes in medicine, including electronic health records, and the increase in the amount of work residents and fellows choose to do from home. Resident decisions to complete work at home should be made in consultation with the resident's/fellow's supervisor. In such circumstances, residents/fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. The requirement provides flexibility for residents/fellows to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum. |
| What are the expectations regarding tracking and monitoring clinical work done from home?<br><br>*[Common Program Requirements: VI.F.1., VI.F.8.a)]* | Types of work from home that must be counted include using an electronic health record and responding to patient care questions. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours.<br><br>Residents and fellows are expected to track the time spent on these activities and report this time to the program director. The program director then will use this information when developing schedules to ensure that residents and fellows are not exceeding 80 hours per week, averaged over four weeks. Decisions about whether to report brief periods devoted to clinical work (e.g., a phone call that lasts just a couple of minutes) are left to the individual resident or fellow. There is no requirement regarding how this time is tracked and documented and no expectation that the program director assume a role in verifying the time reported by the residents and fellows. |

| Which requirements apply to time in the hospital after being called in from home call?<br><br>*[Common Program Requirements: VI.F.8.a)-b)]* | For call taken from home (home or pager call), the time a resident/fellow spends in the hospital after being called in counts toward the weekly clinical and educational work hour limit. The only other numeric clinical and educational work hour requirement that applies is the one day free of clinical and educational work every week that must be free of all patient care responsibilities, which includes at-home call. Program directors must monitor the intensity and workload resulting from at-home call through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities.<br><br>When residents/fellows assigned to at-home call return to the hospital to care for patients, a new time-off period is not initiated, and therefore the requirement for eight hours between shifts does not apply. The frequency and duration of clinical work done from home and time returning to the hospital must not preclude rest or reasonable personal time for residents/fellows. |
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| **General Questions** | |
| How should the averaging of the clinical and educational work hour requirements (e.g., 80-hour weekly limit, one day free of clinical and educational work every week, and call no more frequently than every third night) be handled? For example, what should be done if a resident/fellow takes a vacation week? | Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period (28-31 days); or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance.<br><br>If a resident/fellow takes vacation or other leave, the ACGME requires that vacation or leave days be omitted from the numerator and the denominator for calculating clinical and educational work hours, call frequency, or days off. The requirements do not permit a "rolling" average, because this may mask compliance problems by averaging across high and low clinical and educational work hour rotations. The rotation with the greatest hours and frequency of call must comply with the common clinical and educational work hour requirements. |
| Will the Institutional Requirements be revised to address the Sponsoring Institution's role in the areas of the requirements that address responsibilities that must be shared by the Sponsoring Institution and the program? | The statement "Programs, in partnership with their Sponsoring Institutions," throughout Section VI reflects the need for programs and institutions to work together and recognize that institutional support will be necessary for programs to comply with the new requirements. The next revision of the Institutional Requirements will include changes to align the Institutional Requirements with the Common Program Requirements in these areas and as appropriate. |

| Can the clinical and educational work hour requirements be relaxed over holidays or during other times when a hospital is short-staffed, during periods when some residents/fellows are ill or on leave, or when there is an unusually large patient census or demand for care? | The ACGME expects that clinical and educational work hours in any given four-week period comply with all applicable requirements. This includes months with holidays, during which institutions may have fewer staff members available. During the holiday period, scheduling for the rotation (generally four weeks or a month) must comply with the common and specialty-specific clinical and educational work hour requirements. Further, the schedule during the holidays themselves may not violate common clinical and educational work hour requirements (such as the requirement for adequate rest between clinical and educational work periods), or specialty-specific requirements. |
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| What determines clinical and educational work hour limits for residents/fellows who rotate in another accredited program? | The clinical and educational work hour limits of the program in which the resident/fellow rotates apply to all residents/fellows, both those in the program and rotators from another specialty. This expectation also applies when a program has an exception, but it helps to remember that the standard defines the maximum allowable hours, not required hours or hours for all residents/fellows, so that it is always possible to work fewer hours than the limit. |
| What is the ACGME Resident/Fellow Survey-Common Program Requirements Crosswalk document? How can it help me understand my ACGME resident survey results? | This is a new resource that helps programs understand and interpret their ACGME Resident/Fellow Survey results by mapping ACGME survey questions to the respective and corresponding Common Program Requirements. If a program has a low compliance rate on a particular Resident/Fellow Survey item, the crosswalk document can help the program director identify the area for improvement to comply with the applicable Common Program Requirements. This resource can also help a program's residents/fellows understand the intent of the individual survey questions. The crosswalk document for the Resident/Fellow survey can be found on the ACGME website: https://www.acgme.org/Portals/0/PFAssets/ProgramResources/ResidentFellow%20Survey-Common%20Program%20Requirements%20Crosswalk.pdf?ver=2021-04-30-150131-890.<br><br>A crosswalk document is also available for the annual Faculty Survey: https://www.acgme.org/Portals/0/PFAssets/ProgramResources/Faculty%20Survey-Common%20Program%20Requirements%20Crosswalk.pdf?ver=2021-04-30-144956-250. |

# ACGME
# Common Program Requirements (Fellowship)

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**Revision Information**
ACGME-approved interim revision: September 17, 2022; effective July 1, 2023

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**Definitions**
For more information, see the ACGME Glossary of Terms.

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.

**Osteopathic Recognition**
For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

## Common Program Requirements (Fellowship) Contents

**Common Program Requirements (Fellowship)**

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.

Note: Review Committees may further specify only where indicated by "The Review Committee may/must further specify."

> Background and Intent: These fellowship requirements reflect the fact that these learners have already completed the first phase of graduate medical education. Thus, the Common Program Requirements (Fellowship) are intended to explain the differences.

**Introduction**

**Int.A.**      **Definition of Graduate Medical Education**

*Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.*

*Fellows who have completed residency are able to practice autonomously in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering residency. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.*

*In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty*

*expertise achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.*

**Int.B.** **Definition of Subspecialty**
**[The Review Committee must further specify]**

**Int.C.** **Length of Educational Program**
**[The Review Committee must further specify]**

**I.** **Oversight**

**I.A.** **Sponsoring Institution**

*The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements.*

*When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.*

> **Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the fellows. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.**

**I.A.1.** **The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**

**I.B.** **Participating Sites**

*A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.*

**I.B.1.** **The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**
**[The Review Committee may specify which other specialties/programs must be present at the primary clinical site and/or the expected relationship with a core program in the discipline]**

**I.B.2.** **There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**

**I.B.2.a)** The PLA must:

**I.B.2.a).(1)** be renewed at least every 10 years; and, (Core)

**I.B.2.a).(2)** be approved by the designated institutional official (DIO). (Core)

**I.B.3.** The program must monitor the clinical learning and working environment at all participating sites. (Core)

**I.B.3.a)** At each participating site there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. (Core)

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**Background and Intent:** While all fellowship programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must designate a faculty member responsible for ensuring the quality of the educational experience. In some circumstances, the person charged with this responsibility may not be physically present at the site, but remains responsible for fellow education occurring at the site.

Suggested elements to be considered in PLAs will be found in the Guide to the Common Program Requirements. These include:
- Identifying the faculty members who will assume educational and supervisory responsibility for fellows
- Specifying the responsibilities for teaching, supervision, and formal evaluation of fellows
- Specifying the duration and content of the educational experience
- Stating the policies and procedures that will govern fellow education during the assignment

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**I.B.4.** The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core) [The Review Committee may further specify]

**I.C.** **Workforce Recruitment and Retention**

The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents (if present), fellows, faculty members, senior administrative graduate medical education staff members, and other relevant members of its academic community. (Core)

> **Background and Intent:** It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of individuals underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims.

**I.D.**       **Resources**

**I.D.1.**       The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. **(Core)**

      **[The Review Committee must further specify]**

**I.D.2.**       The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow well-being and provide for:

**I.D.2.a)**       access to food while on duty; **(Core)**

**I.D.2.b)**       safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care; **(Core)**

> **Background and Intent:** Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.

**I.D.2.c)**       clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; **(Core)**

> **Background and Intent:** Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family, as outlined in VI.C.1.c).(1).

**I.D.2.d)**       security and safety measures appropriate to the participating site; and, **(Core)**

**I.D.2.e)**       accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. **(Core)**

**I.D.3.** Fellows must have ready access to subspecialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

**I.E.** **Other Learners and Health Care Personnel**

The presence of other learners and other health care personnel, including but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed fellows' education. (Core)
[The Review Committee may further specify]

> Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.

**II.** **Personnel**

**II.A.** **Program Director**

**II.A.1.** There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

**II.A.1.a)** The Sponsoring Institution's Graduate Medical Education Committee (GMEC) must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)

**II.A.1.a).(1)** Final approval of the program director resides with the Review Committee. (Core)
[For specialties that require Review Committee approval of the program director, the Review Committee may further specify. Program Requirement II.A.1.a).(1) will be deleted for those specialties that do not require Review Committee approval of the program director.]

> Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a fellowship, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC.

**II.A.2.** The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

[The Review Committee must further specify minimum dedicated time for program administration, and will determine whether program leadership refers to the program director or both the program director and associate/assistant program director(s)]

> Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of fellowship programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of fellows, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.
>
> The ultimate outcome of graduate medical education is excellence in fellow education and patient care.
>
> The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the fellowship program, as defined in II.A.4.-II.A.4.a).(12). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.
>
> Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.
>
> In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirement II.B.1. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors, core faculty members, and program coordinators to fulfill their program responsibilities effectively.

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

II.A.3.a)      must include subspecialty expertise and qualifications acceptable to the Review Committee; and, [Core] [The Review Committee may further specify]

II.A.3.b)      must include current certification in the subspecialty for which they are the program director by the American Board of _____ or by the American Osteopathic Board of _____, or subspecialty qualifications that are acceptable to the Review Committee. [Core]

[The Review Committee may further specify acceptable subspecialty qualifications or that only ABMS and AOA certification will be considered acceptable]

[The Review Committee may further specify additional program director qualifications]

**II.A.4.**     **Program Director Responsibilities**

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow education in the context of patient care. (Core)

**II.A.4.a)**     The program director must:

**II.A.4.a).(1)**     be a role model of professionalism; (Core)

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**Background and Intent:** The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

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**II.A.4.a).(2)**     design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

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**Background and Intent:** The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the structural and social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and eliminating health disparities.

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**II.A.4.a).(3)**     administer and maintain a learning environment conducive to educating the fellows in each of the ACGME Competency domains; (Core)

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**Background and Intent:** The program director may establish a leadership team to assist in the accomplishment of program goals. Fellowship programs can be highly complex. In a complex organization the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

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**II.A.4.a).(4)**        have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; [(Core)]

> **Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators may enable the fellows to better manage patient care and provides valuable advancement of the fellows' knowledge. Furthermore, other individuals contribute to the education of fellows in the basic science of the subspecialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the fellow, the program director may designate the individual as a program faculty member or a program core faculty member.**

**II.A.4.a).(5)**        have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; [(Core)]

> **Background and Intent: The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.**
>
> **There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.**

**II.A.4.a).(6)**        submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; [(Core)]

> **Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.**

**II.A.4.a).(7)**        provide a learning and working environment in which fellows have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; [(Core)]

**II.A.4.a).(8)**        ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, not to promote, or renew the appointment of a fellow; [(Core)]

> **Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and fellows.**

**II.A.4.a).(9)** ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

**II.A.4.a).(9).(a)** Fellows must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

**II.A.4.a).(10)** document verification of education for all fellows within 30 days of completion of or departure from the program; (Core)

**II.A.4.a).(11)** provide verification of an individual fellow's education upon the fellow's request, within 30 days; and, (Core)

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**Background and Intent:** Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.

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**II.A.4.a).(12)** provide applicants who are offered an interview with information related to their eligibility for the relevant specialty board examination(s). (Core)

[This requirement may be omitted at the discretion of the Review Committee]

**II.B.** **Faculty**

*Faculty members are a foundational element of graduate medical education – faculty members teach fellows how to care for patients. Faculty members provide an important bridge allowing fellows to grow and become practice ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.*

*Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a*

*professional manner and attending to the well-being of the fellows and themselves.*

> Background and Intent: "Faculty" refers to the entire teaching force responsible for educating fellows. The term "faculty," including "core faculty," does not imply or require an academic appointment.

II.B.1.    There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)
[The Review Committee may further specify]

II.B.2.    Faculty members must:

II.B.2.a)    be role models of professionalism; (Core)

II.B.2.b)    demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)

> Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

II.B.2.c)    demonstrate a strong interest in the education of fellows, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.d)    administer and maintain an educational environment conducive to educating fellows; (Core)

II.B.2.e)    regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)

II.B.2.f)    pursue faculty development designed to enhance their skills at least annually. (Core)
[The Review Committee may further specify regarding faculty development]

[The Review Committee may further specify additional faculty responsibilities]

> Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the fellowship program faculty in the aggregate.

**II.B.3.** **Faculty Qualifications**

**II.B.3.a)** **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.** (Core)

[The Review Committee may further specify]

**II.B.3.b)** **Subspecialty physician faculty members must:**

**II.B.3.b).(1)** **have current certification in the subspecialty by the American Board of _____ or the American Osteopathic Board of _____, or possess qualifications judged acceptable to the Review Committee.** (Core)

[The Review Committee may further specify additional qualifications and/or requirements regarding non-physician faculty members]

**II.B.3.c)** **Any other specialty physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the Review Committee.** (Core)

[The Review Committee may further specify]

**II.B.4.** **Core Faculty**

**Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows.** (Core)

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**Background and Intent:** Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring fellows, and assessing fellows' progress toward achievement of competence in and the autonomous practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of fellows, and also participate in non-clinical activities related to fellow education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting fellow applicants, providing didactic instruction, mentoring fellows, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

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**II.B.4.a)** **Faculty members must complete the annual ACGME Faculty Survey.** (Core)

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-fellow ratio]

[The Review Committee may further specify either:
(1) requirements regarding dedicated time and support for core faculty members' non-clinical responsibilities related to resident education and/or administration of the program, or

(2) requirements regarding the role and responsibilities of core faculty members, inclusive of both clinical and non-clinical activities, and the corresponding time commitment required to meet those responsibilities.] *

[The Review Committee may specify requirements specific to associate program director(s)]

**II.C.            Program Coordinator**

**II.C.1.            There must be a program coordinator. (Core)**

**II.C.2.            The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**
[The Review Committee must further specify minimum dedicated time for the program coordinator]

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Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.

Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison and facilitator between the learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of fellows.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer fellows may not require a full-time coordinator; one coordinator may support more than one program.

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* ACGME-approved revision, effective July 1, 2023 (3/13/2023)

The minimum required dedicated time and support specified in II.C.2.a) is inclusive of activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program coordinator, is also addressed in Institutional Requirement II.B.4. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors, core faculty members, and program coordinators to fulfill their program responsibilities effectively.

II.D.        Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)
[The Review Committee may further specify]

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

III.    Fellow Appointments

III.A.        Eligibility Criteria

III.A.1.            Eligibility Requirements – Fellowship Programs
[Review Committee to choose one of the following:]

Option 1: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada. (Core)

**Option 2: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program or an AOA-approved residency program.** (Core)

III.A.1.a) **[If Review Committee selected Option 1 above:] Fellowship programs must receive verification of each entering fellow's level of competence in the required field using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program.** (Core)

**[If Review Committee selected Option 2 above:] Fellowship programs must receive verification of each entering fellow's level of competence in the required field using ACGME Milestones evaluations from the core residency program.** (Core)

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**Background and Intent:** A reporting feature is available for fellowship programs within ADS to provide fellowship program directors access to the final Milestones report for an active fellow's most recently completed residency program. These reports are available to fellowship program directors in mid-July, and use of this system to retrieve the reports is encouraged. There are a few scenarios in which these reports may not be available, such as if a fellow completed residency in a program not accredited by the ACGME, if a fellow completed residency prior to Milestones implementation, or if a fellow's previous experience could not be matched when entered into the program. For those without Milestones reports, programs must contact the specialty program director from the fellow's most recent residency program to obtain the required information. This new reporting feature can be found in ADS by logging in and navigating to the program's "Reports" tab, and then selecting the "Residency Milestone Retrieval" option.

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III.A.1.b) **[The Review Committee must further specify prerequisite postgraduate clinical education]**

III.A.1.c) **Fellow Eligibility Exception**

**The Review Committee for _____ will allow the following exception to the fellowship eligibility requirements: [Note: Review Committees that selected Option 1 will decide whether or not to allow this exception. This section will be deleted for Review Committees that do not allow the exception and for Review Committees that selected Option 2]**

III.A.1.c).(1) **An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1., but who does meet all of the following additional qualifications and conditions:** (Core)

III.A.1.c).(1).(a) **evaluation 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.1.c).(1).(b)      review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)

III.A.1.c).(1).(c)      verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)

III.A.1.c).(2)      Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

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[If Review Committee allows the exception specified above:]
Background and Intent: An exceptionally qualified international graduate applicant has (1) completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, 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; and/or (c) demonstrated leadership during or after residency. Applicants being considered for these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

In recognition of the diversity of medical education and training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.

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III.B.      Fellow Complement

The program director must not appoint more fellows than approved by the Review Committee. (Core)
[The Review Committee may further specify minimum complement numbers]

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Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through ADS. Permanent increases require prior approval from the Review Committee and temporary increases may also require approval. Specialty-specific instructions for requesting a complement increase are found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.

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III.C.      Fellow Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring fellow, and Milestones evaluations upon matriculation. (Core)
[The Review Committee may further specify]

IV.      Educational Program

*The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*

*The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*

*It is recognized that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.*

IV.A.           Educational Components

The curriculum must contain the following educational components:

IV.A.1.                    a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, fellows, and faculty members; (Core)

IV.A.2.                    competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice in their subspecialty. These must be distributed, reviewed, and available to fellows and faculty members; (Core)

IV.A.3.                    delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty; (Core)

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

IV.A.4.                    structured educational activities beyond direct patient care; and, (Core)

**IV.A.4.a)** **Fellows must be provided with protected time to participate in core didactic activities.** (Core)

> Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

**IV.A.5.** **formal educational activities that promote patient safety-related goals, tools, and techniques.** (Core)

**IV.B.** **ACGME Competencies**

> Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each subspecialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each subspecialty. The focus in fellowship is on subspecialty-specific patient care and medical knowledge, as well as refining the other competencies acquired in residency.

**IV.B.1.** **The program must integrate the following ACGME Competencies into the curriculum:**

**IV.B.1.a)** **Professionalism**

**Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles.** (Core)

**IV.B.1.b)** **Patient Care and Procedural Skills**

> Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

**IV.B.1.b).(1)** **Fellows must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health.** (Core) **[The Review Committee must further specify]**

**IV.B.1.b).(2)** **Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.** (Core) **[The Review Committee may further specify]**

IV.B.1.c)        **Medical Knowledge**

**Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care.** (Core)
**[The Review Committee must further specify]**

IV.B.1.d)        **Practice-based Learning and Improvement**

**Fellows 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 lifelong learning.** (Core)

IV.B.1.e)        **Interpersonal and Communication Skills**

**Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.** (Core)

IV.B.1.f)        **Systems-based Practice**

**Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.** (Core)

IV.C.        **Curriculum Organization and Fellow Experiences**

IV.C.1.        **The curriculum must be structured to optimize fellow educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events.** (Core)
**[The Review Committee must further specify]**

IV.C.2.        **The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of substance use disorder.** (Core)
**[The Review Committee may further specify]**

**[The Review Committee may specify required didactic and clinical experiences]**

IV.D.        **Scholarship**

*Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically,*

*evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching.*

*The ACGME recognizes the diversity of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.*

| IV.D.1. | **Program Responsibilities** |
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**IV.D.1.a)**        The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)
[The Review Committee may further specify]

**IV.D.1.b)**        The program in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate fellow and faculty involvement in scholarly activities. (Core)
[The Review Committee may further specify]

**IV.D.2.**        **Faculty Scholarly Activity**

**IV.D.2.a)**        Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

**IV.D.2.b)**        The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

**[Review Committee will choose to require either IV.D.2.b).(1) or both IV.D.2.b).(1) and IV.D.2.b).(2)]**

> Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the fellows' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

**IV.D.2.b).(1)**      **faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor;** (Outcome)
**[The Review Committee may further specify]**

**IV.D.2.b).(2)**      **peer-reviewed publication.** (Outcome)
**[The Review Committee may further specify]**

**IV.D.3.**      **Fellow Scholarly Activity**
**[The Review Committee may further specify]**

**IV.E.**      **Independent Practice**

*Fellowship programs may assign fellows to engage in the independent practice of their core specialty during their fellowship program.*

**IV.E.1.**      **If programs permit their fellows to utilize the independent practice option, it must not exceed 20 percent of their time per week or 10 weeks of an academic year.** (Core)
**[This section will be deleted for those Review Committees that choose not to permit the independent practice option. For those that choose to permit this option, the Review Committee may further specify.]**

> Background and Intent: Fellows who have previously completed residency programs have demonstrated sufficient competence to enter autonomous practice within their core specialty. This option is designed to enhance fellows' maturation and competence in their core specialty. This enables fellows to occupy a dual role in the health system: as learners in their subspecialty, and as credentialed practitioners in their core specialty. Hours worked in independent practice during fellowship still fall under the clinical and educational work hour limits. See Guide to the Common Program Requirements for more details.

## V.    Evaluation

## V.A.         Fellow Evaluation

## V.A.1.         Feedback and Evaluation

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring fellow learning* and providing ongoing feedback that can be used by fellows to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:
- fellows identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where fellows are struggling and address problems immediately

Summative evaluation is *evaluating a fellow's learning* by comparing the fellows against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a new specialist to one with growing subspecialty expertise.

**V.A.1.a)**         Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. (Core) [The Review Committee may further specify]

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Fellows require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for fellows who have deficiencies that may result in a poor final rotation evaluation.

**V.A.1.b)**         Evaluation must be documented at the completion of the assignment. (Core)

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| **V.A.1.b).(1)** | **For block rotations of greater than three months in duration, evaluation must be documented at least every three months.** (Core) |
| **V.A.1.b).(2)** | **Longitudinal experiences such as continuity clinic in the context of other clinical responsibilities must be evaluated at least every three months and at completion.** (Core) |
| **V.A.1.c)** | **The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must:** (Core) |
| **V.A.1.c).(1)** | **use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and,** (Core) |
| **V.A.1.c).(2)** | **provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice.** (Core) |

> **Background and Intent:** The trajectory to autonomous practice in a subspecialty is documented by the subspecialty-specific Milestones evaluation during fellowship. These Milestones detail the progress of a fellow in attaining skill in each competency domain. It is expected that the most growth in fellowship education occurs in patient care and medical knowledge, while the other four domains of competency must be ensured in the context of the subspecialty. They are developed by a subspecialty group and allow evaluation based on observable behaviors. The Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific fellow.

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| **V.A.1.d)** | **The program director or their designee, with input from the Clinical Competency Committee, must:** |
| **V.A.1.d).(1)** | **meet with and review with each fellow their documented semi-annual evaluation of performance, including progress along the subspecialty-specific Milestones.** (Core) |
| **V.A.1.d).(2)** | **assist fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and,** (Core) |
| **V.A.1.d).(3)** | **develop plans for fellows failing to progress, following institutional policies and procedures.** (Core) |

> **Background and Intent:** Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a fellow's performance at least at the end of each rotation. The program director or their designee will review those

evaluations, including their progress on the Milestones, at a minimum of every six months. Fellows should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, fellows should develop an individualized learning plan.

Fellows who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the fellow, will take a variety of forms based on the specific learning needs of the fellow. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of fellow progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

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| **V.A.1.e)** | At least annually, there must be a summative evaluation of each fellow that includes their readiness to progress to the next year of the program, if applicable. (Core) |
| **V.A.1.f)** | The evaluations of a fellow's performance must be accessible for review by the fellow. (Core)<br>[The Review Committee may further specify under any requirement in V.A.1.-V.A.1.f)] |
| **V.A.2.** | Final Evaluation |
| **V.A.2.a)** | The program director must provide a final evaluation for each fellow upon completion of the program. (Core) |
| **V.A.2.a).(1)** | The subspecialty-specific Milestones, and when applicable the subspecialty-specific Case Logs, must be used as tools to ensure fellows are able to engage in autonomous practice upon completion of the program. (Core) |
| **V.A.2.a).(2)** | The final evaluation must: |
| **V.A.2.a).(2).(a)** | become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy; (Core) |
| **V.A.2.a).(2).(b)** | verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core) |
| **V.A.2.a).(2).(c)** | be shared with the fellow upon completion of the program. (Core) |
| **V.A.3.** | A Clinical Competency Committee must be appointed by the program director. (Core) |

V.A.3.a) At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as fellow advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. Inclusivity is an important consideration in the appointment of Clinical Competency Committee members, ensuring diverse participation to achieve fair evaluation. The program director has final responsibility for fellow evaluation and promotion decisions.

The program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's fellows. There may be additional members of the Clinical Competency Committee.

V.A.3.b) The Clinical Competency Committee must:

V.A.3.b).(1) review all fellow evaluations at least semi-annually; (Core)

V.A.3.b).(2) determine each fellow's progress on achievement of the subspecialty-specific Milestones; and, (Core)

V.A.3.b).(3) meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (Core)

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

Background and Intent: The program director is responsible for the educational program and for all educators. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to fellowship program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the fellow and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with fellows desire feedback on their education, clinical care, and research. If a faculty member does not

interact with fellows, feedback is not required. With regard to the diverse operating environments and configurations, the fellowship program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the fellows in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

**V.B.1.a)** This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)

**V.B.1.b)** This evaluation must include written, confidential evaluations by the fellows. (Core)

**V.B.2.** Faculty members must receive feedback on their evaluations at least annually. (Core)

**V.B.3.** Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the fellows' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

**V.C.** Program Evaluation and Improvement

**V.C.1.** The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

**V.C.1.a)** The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one fellow. (Core)

**V.C.1.b)** Program Evaluation Committee responsibilities must include:

**V.C.1.b).(1)** review of the program's self-determined goals and progress toward meeting them; (Core)

**V.C.1.b).(2)**        guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)

**V.C.1.b).(3)**        review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)

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**Background and Intent:** To achieve its mission and educate and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of fellows and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims. The Program Evaluation Committee advises the program director through program oversight.

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**V.C.1.c)**        The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate fellow and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)

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**Background and Intent:** Other data to be considered for assessment include:
- **Curriculum**
- **ACGME letters of notification, including citations, Areas for Improvement, and comments**
- **Quality and safety of patient care**
- **Aggregate fellow and faculty well-being; recruitment and retention; workforce diversity, including graduate medical education staff and other relevant academic community members; engagement in quality improvement and patient safety; and scholarly activity**
- **ACGME Fellow and Faculty Survey results**
- **Aggregate fellow Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance**
- **Aggregate faculty evaluation and professional development**

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**V.C.1.d)**        The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

**V.C.1.e)**        The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the fellows and the members of the teaching faculty, and be submitted to the DIO. (Core)

**V.C.2.**        The program must participate in a Self-Study and submit it to the DIO. (Core)

> **Background and Intent:** Outcomes of the documented Annual Program Evaluation can be integrated into the accreditation Self-Study process. The accreditation Self-Study is an objective, comprehensive evaluation of the fellowship program, with the aim of improving it. Underlying the accreditation Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the accreditation Self-Study are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the [accreditation Self-Study process](#) is available on the ACGME website.

**V.C.3.**  *One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.*

*The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board. [If certification in the subspecialty is not offered by the ABMS and/or the AOA, V.C.3.a)-V.C.3.f) will be omitted.]*

**V.C.3.a)**  For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)

**V.C.3.b)**  For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)

**V.C.3.c)**  For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)

**V.C.3.d)**  For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)

**V.C.3.e)**  For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty. [Outcome]

> **Background and Intent:** Setting a single standard for pass rate that works across subspecialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.
>
> There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

**V.C.3.f)**  Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier. [Core]

> **Background and Intent:** It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from fellowship graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.
>
> The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.
>
> In the future, the ACGME may establish parameters related to ultimate board certification rates.

**VI.  The Learning and Working Environment**

*Fellowship 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 fellows today*

- *Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice*

- *Excellence in professionalism*

- *Appreciation for the privilege of providing care for patients*

- *Commitment to the well-being of the students, residents, fellows, 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

**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).(2)** Patient Safety Events

*Reporting, investigation, and follow-up of safety 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).(2).(a)** Residents, fellows, faculty members, and other clinical staff members must:

**VI.A.1.a).(2).(a).(i)** know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, **(Core)**

**VI.A.1.a).(2).(a).(ii)** be provided with summary information of their institution's patient safety reports. **(Core)**

**VI.A.1.a).(2).(b)** Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement

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).(3)**                    **Quality Metrics**

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

**VI.A.1.a).(3).(a)**                **Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. [Core]**
[The Review Committee may further specify]

**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 fellow'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)**                **Fellows 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.a).(1).(a)**                **This information must be available to fellows, faculty members, other members of the health care team, and patients. [Core]**

Background and Intent: Each patient will 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.

**VI.A.2.a).(2)**                **The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow'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.]**

**Background and Intent:** Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of fellow-patient interactions, education and training locations, and fellow skills and abilities, even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a fellow gains more experience, even with the same patient condition or procedure. The level of supervision for each fellow is commensurate with that fellow's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.

**VI.A.2.b)**          **Levels of Supervision**

To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

**VI.A.2.b).(1)**          **Direct Supervision:**

**VI.A.2.b).(1).(a)**          the supervising physician is physically present with the fellow during the key portions of the patient interaction; or,
[The Review Committee may further specify]

**VI.A.2.b).(1).(b)**          the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
[The Review Committee may choose not to permit VI.A.2.b).(1).(b);The Review Committee may further specify]

**VI.A.2.b).(2)**          **Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision.**

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

**VI.A.2.c)**          **The program must define when physical presence of a supervising physician is required.** (Core)

**VI.A.2.d)**          **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient**

care delegated to each fellow must be assigned by the program director and faculty members. (Core)

**VI.A.2.d).(1)** The program director must evaluate each fellow'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 fellows based on the needs of the patient and the skills of each fellow. (Core)

**VI.A.2.d).(3)** Fellows should serve in a supervisory role to junior fellows and 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 fellows must communicate with the supervising faculty member(s). (Core)

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

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**Background and Intent:** The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

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**VI.A.2.f)** Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow 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 fellows and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

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**Background and Intent:** This requirement emphasizes the professional responsibility of fellows and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of fellows, faculty members, and other members of the care team to be observant, to intervene, and/or to escalate their concern about fellow and faculty member fitness for work, depending on the situation, and in accordance with institutional policies. This includes recognition of impairment,

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> including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and 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 practitioner.

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

VI.B.2.a)　　　　　be accomplished without excessive reliance on fellows to fulfill non-physician obligations; (Core)

> Background and Intent: Routine reliance on fellows to fulfill non-physician obligations increases work compression for fellows 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 fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by fellows routinely and must be kept to a minimum to optimize fellow education.

VI.B.2.b)　　　　　ensure manageable patient care responsibilities; and, (Core)
　　　　　　　　　　　　[The Review Committee may further specify]

> Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty/subspecialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty- and subspecialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty/subspecialty, should carefully assess how the assignment of patient care responsibilities can affect work compression.

VI.B.2.c)　　　　　include efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)

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)

> Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, fellows, and faculty.

VI.B.4.　　　　　Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)

**VI.B.5.**     Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff. (Core)

Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

**VI.B.6.**     Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

**VI.C.**     Well-Being

*Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of fellowship training.*

*Fellows and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares fellows with the skills and attitudes needed to thrive throughout their careers.*

**VI.C.1.**     The responsibility of the program, in partnership with the Sponsoring Institution, must include:

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

**VI.C.1.b)**     evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)

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 fellow 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 safety events.

**VI.C.1.c)** policies and programs that encourage optimal fellow 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. The intent of this requirement is to ensure that fellows have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Fellows must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

**VI.C.1.c).(1)** Fellows 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.d)** education of fellows and faculty members in:

**VI.C.1.d).(1)** identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)

**VI.C.1.d).(2)** recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)

**VI.C.1.d).(3)** access to appropriate tools for self-screening. (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 use disorder. Materials and more information are available in Learn at ACGME (https://dl.acgme.org/pages/well-being-tools-resources).

Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions and may be 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 fellows and faculty members are able to report their concerns when another fellow 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. Fellows 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/well-being 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)**            providing 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 fellows 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 fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. (Core)

**VI.C.2.a)**            The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)

**VI.C.2.b)**            These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. (Core)

Background and Intent: Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

**VI.D.**            **Fatigue Mitigation**

**VI.D.1.**            Programs must educate all fellows and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (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 fellows 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.

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.** The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows 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 fellow must be based on PGY level, patient safety, fellow 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 fellows. Faculty members and program directors need to make sure fellows function in an environment that has safe patient care and a sense of fellow well-being. It is an essential responsibility of the program director to monitor fellow workload. Workload should be distributed among the fellow team and interdisciplinary teams to minimize work compression.

**VI.E.2.** Teamwork

Fellows must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the subspecialty and larger health system. (Core)
[The Review Committee may further specify]

Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

**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-off

processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c)                  **Programs must ensure that fellows are competent in communicating with team members in the hand-off process.** (Outcome)

VI.F.         **Clinical Experience and Education**

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

Background and Intent: 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 terms are used 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 fellows' 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 fellows 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 fellows 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.

*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 fellows are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work fellows choose to do from home. The requirement provides flexibility for fellows to do this while ensuring that the time spent by fellows 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. Fellow 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 fellow's supervisor. In such circumstances, fellows should be mindful of their

**professional responsibility to complete work in a timely manner and to maintain patient confidentiality.**

**Fellows 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 fellow. Programs will need to factor in time fellows are spending on clinical work at home when schedules are developed to ensure that fellows 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 fellows report their time from home and that schedules are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.**

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

VI.F.2.a)　　　　　　　　**Fellows should have eight hours off between scheduled clinical work and education periods.** (Detail)

**Background and Intent: There may be circumstances when fellows 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 occurs within the context of the 80-hour and the one-day-off-in-seven requirements. While it is expected that fellow schedules will be structured to ensure that fellows are provided with a minimum of eight hours off between scheduled work periods, it is recognized that fellows 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 fellows 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.b)　　　　　　　　**Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call.** (Core)

**Background and Intent: Fellows 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, fellows are encouraged to prioritize sleep over other discretionary activities.**

VI.F.2.c)　　　　　　　　**Fellows 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 fellow needs. It is strongly recommended that fellows' 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 fellows 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 fellows 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 fellow 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 fellows 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 fellow education. Additional patient care responsibilities must not be assigned to a fellow 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 fellow continue to function as a member of the team in an environment where other members of the team can assess fellow fatigue, and that supervision for post-call fellows 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 fellow, 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; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)

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

Background and Intent: This requirement is intended to provide fellows 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 fellow may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows 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*. (Detail) |

**Background and Intent:** Exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all fellows 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 fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety. (Core) |

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

**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. (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 |

Fellows 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 fellows 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 fellow. (Core)

[The Review Committee may further specify under any requirement in VI.F.-VI.F.8.a).(1)]

Background and Intent: As noted in VI.F.1., clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows 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 fellowship programs, Review Committees will look at the overall impact of at-home call on fellow rest and personal time.

# ACGME

# Institutional Requirements

ACGME-approved focused revision: September 26, 2021; effective July 1, 2022

## ACGME Institutional Requirements

I.        Structure for Educational Oversight

I.A.              Sponsoring Institution

I.A.1.              Residency and fellowship programs accredited by the 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, specialty-/subspecialty-specific Program, and Recognition 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 designated institutional official (DIO). (Core)

I.A.5.a)              This individual, 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, specialty-/subspecialty-specific Program, and Recognition Requirements. (Core)

I.A.5.b)              The DIO must:

I.A.5.b).(1)              approve program letters of agreement (PLAs) that govern relationships between each program and each participating site providing a required assignment for residents/fellows in the program; (Core)

I.A.5.b).(2)              oversee submissions of the Annual Update for each program and the Sponsoring Institution to the ACGME; and, (Core)

I.A.5.b).(3)              after GMEC approval, oversee the submission of applications for ACGME accreditation and recognition,

requests for voluntary withdrawal of accreditation and recognition, and requests for changes in residency and fellowship program complements. (Core)

I.A.6.        The Sponsoring Institution must identify a governing body, which is the single entity that maintains authority over and responsibility for the Sponsoring Institution and each of its ACGME-accredited programs. (Core)

I.A.7.        A written statement, 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, must document the Sponsoring Institution's:

I.A.7.a)        GME mission; and, (Core)

I.A.7.b)        commitment to GME by ensuring the provision of the necessary administrative, educational, financial, human, and clinical resources. (Core)

I.A.8.        The Sponsoring Institution must complete a Self-Study prior to its 10-Year Accreditation Site Visit. (Core)

I.A.9.        Any Sponsoring Institution or participating site that is a hospital must maintain accreditation to provide patient care. (Core)

I.A.9.a)        Accreditation for patient care must be provided by:

I.A.9.a).(1)        an entity granted "deeming authority" for participation in Medicare under federal regulations; or, (Core)

I.A.9.a).(2)        an entity certified as complying with the conditions of participation in Medicare under federal regulations. (Core)

I.A.10.        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 within 30 days of such loss. Based on the particular circumstances, the ACGME may invoke its procedures related to alleged egregious and/or catastrophic events. (Core)

I.A.11.        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 Institutional Review Committee within 30 days of such loss or restriction. Based on the particular circumstances, the ACGME may invoke its procedures related to alleged egregious and/or catastrophic events. (Core)

I.B.        Graduate Medical Education Committee (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 DIO; (Core)

I.B.1.b).(3)                    one of the program's core faculty members other than the program director, if the program includes core faculty members other than the program director; (Core)

I.B.1.b).(4)                    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).(5)                    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).(6)                    one or more individuals who are actively involved in GME, are outside the program, and are not the DIO or the quality improvement or patient safety member. (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.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)          ACGME accreditation and recognition statuses 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 program evaluation(s) and Self-Study(ies); (Core)

I.B.4.a).(5)          ACGME-accredited programs' implementation of institutional policy(ies) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence, at least annually; (Core)

I.B.4.a).(6)          all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution; and, (Core)

I.B.4.a).(7)          the provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided. (Detail)

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

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

I.B.4.b).(2)          GMEC subcommittee actions that address required GMEC responsibilities; (Core)

I.B.4.b).(3)          annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits; (Core)

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

I.B.4.b).(5)          requests for permanent changes in resident/fellow complement; (Core)

I.B.4.b).(6)          major changes in each of its ACGME-accredited programs' structure or duration of education, including any change in the designation of a program's primary clinical site; (Core)

I.B.4.b).(7)          additions and deletions of each of its ACGME-accredited programs' participating sites; (Core)

I.B.4.b).(8)          appointment of new program directors; (Core)

I.B.4.b).(9)          progress reports requested by a Review Committee; (Core)

I.B.4.b).(10)          responses to Clinical Learning Environment Review (CLER) reports; (Core)

I.B.4.b).(11)          requests for exceptions to clinical and educational work hour requirements; (Core)

I.B.4.b).(12)          voluntary withdrawal of ACGME program accreditation or recognition; (Core)

I.B.4.b).(13)          requests for appeal of an adverse action by a Review Committee; and, (Core)

I.B.4.b).(14)          appeal presentations to an ACGME Appeals Panel; and, (Core)

I.B.4.b).(15)          exceptionally qualified candidates for resident/fellow appointments who do not satisfy the Sponsoring Institution's resident/fellow eligibility policy and/or resident/fellow eligibility requirements in the Common Program Requirements. (Core)

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

I.B.5.a)          The GMEC must identify institutional performance indicators for the AIR, to include, at a minimum: (Core)

I.B.5.a).(1)          the most recent ACGME institutional letter of notification; (Core)

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

I.B.5.a).(3)    each of its ACGME-accredited programs' ACGME accreditation information, including accreditation and recognition statuses and citations. (Core)

I.B.5.b)    The DIO must annually submit a written executive summary of the AIR to the Sponsoring Institution's Governing Body. The written executive summary must include: (Core)

I.B.5.b).(1)    a summary of institutional performance on indicators for the AIR; and, (Core)

I.B.5.b).(2)    action plans and performance monitoring procedures resulting from the AIR. (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: (Core)

I.B.6.a).(1)    establishes a variety of criteria for identifying underperformance that includes, at a minimum, program accreditation statuses of Initial Accreditation with Warning, Continued Accreditation with Warning, and adverse accreditation statuses as described by ACGME policies; and, (Core)

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

II.    Institutional Resources

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

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

II.A.2.    the DIO engages in professional development applicable to 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 partnership with each of its ACGME-accredited programs, must ensure the availability of adequate resources for resident/fellow education, including:

II.B.1.        support and dedicated time for the program director(s) to effectively carry out educational, administrative, and leadership responsibilities, as described in the Institutional, Common, and specialty-/subspecialty-specific Program Requirements; (Core)

II.B.2.        support for core faculty members to ensure both effective supervision and quality resident/fellow education; (Core)

II.B.3.        support for professional development applicable to program directors' and core faculty members' responsibilities as educational leaders; (Core)

II.B.4.        support and time for the program coordinator(s) to effectively carry out responsibilities; and, (Core)

II.B.5.        resources, including space, technology, and supplies, 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 all residents/fellows from within and across the Sponsoring Institution's ACGME-accredited programs to communicate and exchange information with other residents/fellows 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 directly 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 partnership with 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 electronic medical literature databases and specialty-/subspecialty-specific and other appropriate full-text 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: (Core)

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; (Core)

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; and, (Core)

II.F.1.c)      institutional processes for ensuring the availability of resources to support residents'/fellows' well-being and education by minimizing impact to clinical assignments resulting from leaves of absence. (Core)

III.      The 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 and faculty members have the opportunity to raise concerns and provide feedback without intimidation or retaliation, and in a confidential manner, as appropriate. (Core)

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

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, (Core)

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

| 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) | in partnership with its ACGME-accredited program(s), ensure and monitor effective, structured patient hand-over processes to facilitate continuity of care and patient safety at participating sites. (Core) |
| III.B.4. | Supervision and Accountability |
| III.B.4.a) | The Sponsoring Institution must oversee: |
| III.B.4.a).(1) | supervision of residents/fellows consistent with institutional and program-specific policies; and, (Core) |
| III.B.4.a).(2) | mechanisms by which residents/fellows can report inadequate supervision and accountability in a protected manner that is free from reprisal. (Core) |
| III.B.5. | Clinical Experience and Education |
| III.B.5.a) | The Sponsoring Institution must oversee: |
| III.B.5.a).(1) | resident/fellow clinical and educational work 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.a).(2) | systems of care and learning and working environments that facilitate fatigue mitigation for residents/fellows; and, (Core) |
| III.B.5.a).(3) | an educational program for residents/fellows and faculty members in fatigue mitigation. (Core) |
| III.B.6. | Professionalism |
| III.B.6.a) | The Sponsoring Institution, in partnership with the program director(s) of its ACGME-accredited program(s), must provide a |

culture of professionalism that supports patient safety and personal responsibility. (Core)

III.B.6.b) The Sponsoring Institution, in partnership with its ACGME-accredited program(s), must educate residents/fellows 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)

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

III.B.6.c).(1) residents'/fellows' and core faculty members' fulfillment of educational and professional responsibilities, including scholarly pursuits; and, (Core)

III.B.6.c).(2) accurate completion of required documentation by residents/fellows. (Core)

III.B.6.d) The Sponsoring Institution must ensure that its ACGME-accredited program(s) provide(s) a professional, equitable, respectful and civil environment that is free from unprofessional behavior, including discrimination, sexual, and other forms of harassment, mistreatment, abuse, and/or coercion of residents/fellows, other learners, faculty members, and staff members. (Core)

III.B.6.d).(1) The Sponsoring Institution, in partnership with its ACGME-accredited program(s), must have a process for education of residents/fellows and faculty members regarding unprofessional behavior, and a confidential process for reporting, investigating, monitoring, and addressing such concerns in a timely manner. (Core)

III.B.7. Well-Being

III.B.7.a) The Sponsoring Institution must oversee its ACGME-accredited program's(s') fulfillment of responsibility to address well-being of residents/fellows and faculty members, consistent with the Common and specialty-/subspecialty-specific Program Requirements, addressing areas of non-compliance in a timely manner. (Core)

III.B.7.b) The Sponsoring Institution, in partnership with its ACGME-accredited program(s), must educate faculty members and residents/fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. This responsibility includes educating residents/fellows and faculty members in how to recognize those symptoms in themselves, and how to seek appropriate care. (Core)

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|---|---|
| III.B.7.c) | The Sponsoring Institution, in partnership with its ACGME-accredited program(s), must: (Core) |
| III.B.7.c).(1) | encourage residents/fellows and faculty members to alert their program director, DIO, 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) |
| III.B.7.c).(2) | provide access to appropriate tools for self screening; and, (Core) |
| III.B.7.c).(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) |
| III.B.7.d) | The Sponsoring Institution must ensure a healthy and safe clinical and educational environment that provides for: (Core) |
| III.B.7.d).(1) | access to food during clinical and educational assignments; (Core) |
| III.B.7.d).(2) | sleep/rest facilities that are safe, quiet, clean, and private, and that must be available and accessible for residents/fellows, with proximity appropriate for safe patient care; (Core) |
| III.B.7.d).(3) | safe transportation options for residents/fellows who may be too fatigued to safely return home on their own; (Core) |
| III.B.7.d).(4) | clean and private facilities for lactation with proximity appropriate for safe patient care, and clean and safe refrigeration resources for the storage of breast milk; (Core) |
| III.B.7.d).(5) | safety and security measures appropriate to the clinical learning environment site; and, (Core) |
| III.B.7.d).(6) | accommodations for residents/fellows with disabilities, consistent with the Sponsoring Institution's policy. (Core) |
| III.B.8. | The Sponsoring Institution, in partnership with each of its programs, must engage in practices that focus on ongoing, mission-driven, systematic recruitment and retention of a diverse and inclusive workforce of residents/fellows, faculty members, senior administrative staff members, and other relevant members of its GME community. (Core) |

IV.     Institutional GME Policies and Procedures

IV.A.         The Sponsoring Institution must demonstrate adherence to all institutional graduate medical education policies and procedures. (Core)

IV.B.         Resident/Fellow Appointments

IV.B.1.         The Sponsoring Institution must have written policies and procedures for resident/fellow recruitment, selection, eligibility, and appointment consistent with ACGME Institutional and Common Program Requirements, and Recognition Requirements (if applicable), and must monitor each of its ACGME-accredited programs for compliance. (Core)

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

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

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

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

IV.B.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. (Core)

IV.B.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 the applicant's eventual appointments. (Core)

IV.B.3.a)         Information that is provided must include:

IV.B.3.a).(1)         stipends, benefits, professional liability coverage, and disability insurance accessible to residents/fellows; (Core)

IV.B.3.a).(2)         institutional policy(ies) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence; and, (Core)

IV.B.3.a).(3)         health insurance accessible to residents/fellows and their eligible dependents. (Core)

IV.C.    Agreement of Appointment/Contract

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

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

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

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

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

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

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

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

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

IV.C.2.i)    vacation and leave(s) of absence for residents/fellows, including medical, parental, and caregiver leave(s) of absence, and compliant with applicable laws; (Core)

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

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

IV.C.2.l)    institutional policies and procedures regarding resident/fellow clinical and educational work hours and moonlighting. (Core)

IV.D.    Promotion, Appointment Renewal and Dismissal

IV.D.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's/fellow's appointment. (Core)

IV.D.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.D.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.E.   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.F.   Professional Liability Insurance

IV.F.1.   The Sponsoring Institution must ensure that residents/fellows are provided 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.F.2.   The Sponsoring Institution must ensure that residents/fellows are provided with: (Core)

IV.F.2.a)   official documentation of the details of their professional liability coverage before the start date of resident/fellow appointments; and, (Core)

IV.F.2.b)   written advance notice of any substantial change to the details of their professional liability coverage. (Core)

IV.G.   Health and Disability Insurance

IV.G.1.   The Sponsoring Institution must ensure that residents/fellows are provided with health insurance benefits for residents/fellows and their eligible dependents beginning on the first day of insurance eligibility. (Core)

IV.G.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.G.2.   The Sponsoring Institution must ensure that residents/fellows are provided with disability insurance benefits for residents/fellows beginning on the first day of disability insurance eligibility. (Core)

IV.G.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.H.     Vacation and Leaves of Absence

IV.H.1.     The Sponsoring Institution must have a policy for vacation and leaves of absence, consistent with applicable laws. This policy must: (Core)

IV.H.1.a)     provide residents/fellows with a minimum of six weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, starting the day the resident/fellow is required to report; (Core)

IV.H.1.b)     provide residents/fellows with at least the equivalent of 100 percent of their salary for the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken; (Core)

IV.H.1.c)     provide residents/fellows with a minimum of one week of paid time off reserved for use outside of the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken; (Core)

IV.H.1.d)     ensure the continuation of health and disability insurance benefits for residents/fellows and their eligible dependents during any approved medical, parental, or caregiver leave(s) of absence; (Core)

IV.H.1.e)     describe the process for submitting and approving requests for leaves of absence; (Core)

IV.H.1.f)     be available for review by residents/fellows at all times; and, (Core)

IV.H.1.g)     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.I.     Resident Services

IV.I.1.     Behavioral Health: The Sponsoring Institution must ensure that residents/fellows are provided with access to confidential counseling and behavioral health services. (Core)

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

IV.I.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 and in a timely manner, consistent with applicable laws and regulations. (Core)

IV.I.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.5.  Discrimination: The Sponsoring Institution must have policies and procedures, not necessarily GME-specific, prohibiting discrimination in employment and in the learning and working environment, consistent with all applicable laws and regulations. (Core)

IV.J.  Supervision

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

IV.J.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.K.  Clinical and Educational Work Hours: The Sponsoring Institution must maintain a clinical and educational work hour policy that ensures effective oversight of institutional and program-level compliance with ACGME clinical and educational work hour requirements. (Core)

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

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

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

IV.K.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, (Core)

IV.K.1.d)  the Sponsoring Institution or individual ACGME-accredited programs may prohibit moonlighting by residents/fellows. (Core)

IV.L.  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. (Core)

IV.M.         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. (Core)

IV.N.         Substantial Disruptions in Patient Care or Education: The Sponsoring Institution must maintain a policy consistent with ACGME Policies and Procedures that addresses support for each of its ACGME-accredited programs and residents/fellows in the event of a disaster or other substantial disruption in patient care or education. (Core)

IV.N.1.       This policy must include information about assistance for continuation of salary, benefits, professional liability coverage, and resident/fellow assignments. (Core)

IV.O.         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: (Core)

IV.O.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, (Core)

IV.O.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. (Core)

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***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.

Frequently Asked Questions: Institutional Requirements
ACGME

| Question | Answer |
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| **Structure for Educational Oversight** | |
| What makes up a Sponsoring Institution?<br><br>*[Institutional Requirement: I.A.1.]* | A Sponsoring Institution is an entity that oversees, supports, and administers one or more ACGME-accredited residency/fellowship programs. A governing body (which can be a person or a group) has ultimate authority over and responsibility for graduate medical education (GME) in a Sponsoring Institution. A designated institutional official (DIO) collaborates with a Graduate Medical Education Committee (GMEC) to ensure a Sponsoring Institution's and its programs' substantial compliance with the applicable ACGME Institutional, Common, and specialty-/subspecialty-specific Program Requirements. |
| What is the purpose of the organizational charts required as part of the Institutional Review Uploads in the Accreditation Data System (ADS)?<br><br>*[Institutional Requirement: I.A.1.]* | A Sponsoring Institution's organizational chart(s) should illustrate the authority of a single governing body and its relationships with a DIO, GMEC, and other individuals or entities with responsibility for GME in the Sponsoring Institution (e.g., program directors, participating sites). While a variety of organizational structures can be found among ACGME-accredited Sponsoring Institutions, a substantially compliant Sponsoring Institution has a DIO who collaborates with a GMEC with appropriate reports to a singular governing body. |
| What are Recognition Requirements?<br><br>*[Institutional Requirement: I.A.2.]* | Supplemental to accreditation, recognition is an acknowledgement of identified elements or categories of a program or Sponsoring Institution. The ACGME has requirements for recognition of ACGME-accredited programs that demonstrate the commitment to teaching and assessing osteopathic principles and practice (OPP) in GME. The ACGME is also developing requirements for recognition of Sponsoring Institutions with non-standard training programs for exchange visitor physicians on J-1 visas. If the Sponsoring Institution or its program(s) have a recognition status, the Sponsoring Institution is responsible for ensuring compliance with all applicable Recognition Requirements. |
| How long can a Sponsoring Institution have a status of Initial Accreditation without any | The Initial Accreditation period for most Sponsoring Institutions is approximately two years. The Sponsoring Institution is responsible for developing at least one ACGME- |

| Question | Answer |
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| residents/fellows in ACGME-accredited programs?<br><br>*[Institutional Requirement: I.A.2.]* | accredited program with active residents/fellows at the end of the Initial Accreditation period. An accreditation site visit at the end of the Initial Accreditation period will be scheduled even if a Sponsoring Institution has no accredited programs. The IRC may cite Institutional Requirement I.A.2. if a Sponsoring Institution does not have programs that have achieved ACGME accreditation. |
| Are there limits on who can serve as a DIO?<br><br>*[Institutional Requirements: I.A.5.a); II.A.1.]* | While the Institutional Requirements do not specify qualifications of a DIO, it is expected that the DIO effectively collaborates with the GMEC to ensure compliance with the applicable Common, specialty-specific, Institutional, and Recognition Requirements. The Sponsoring Institution's organizational structure should reflect the DIO's authority and responsibility for oversight of each of its sponsored ACGME-accredited programs. While it is currently acceptable for one individual to serve as DIO for more than one Sponsoring Institution, each Sponsoring Institution must define the financial support and protected time committed to the DIO for responsibilities relating to oversight, education, administration, and leadership in that Sponsoring Institution only. Additionally, the DIO can serve in other roles within the Sponsoring Institution, provided that the Sponsoring Institution ensures the necessary financial support, professional development, and protected time for the fulfillment of required DIO responsibilities.<br><br>A program director or faculty member of an ACGME-accredited program may simultaneously serve as a DIO. When a DIO is also a program director or faculty member, the Sponsoring Institution should carefully manage conflicts of interest that may arise for the DIO in program oversight activities, such as Special Reviews of underperforming programs. Such DIOs may have a designee and may be recused from some GMEC oversight functions, as appropriate. |
| How is DIO approval of program letters of agreement (PLAs) documented?<br><br>*[Institutional Requirement: I.A.5.b).(1)]* | Approval is documented by the presence of the DIO's signature on the PLA. Sponsoring Institutions have flexibility to determine efficient processes for documenting this approval. |

| Question | Answer |
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| How does the DIO demonstrate oversight of programs' Annual Update submissions to the ACGME? [Institutional Requirement: I.A.5.b).(2)] | The requirement acknowledges the role of the DIO in overseeing programs' submissions of accreditation information to the ACGME. The DIO, with the institutional coordinator(s), is expected to document this oversight by approving programs' Annual Update submissions in ADS. The approval process includes a mechanism for DIOs and institutional coordinators to provide confidential feedback to programs prior to approval. |
| What are the essential components in a Sponsoring Institution's written statement of commitment to GME? [Institutional Requirement: I.A.7.-I.A.7.b)] | The Sponsoring Institution's written statement of commitment statement must include: 1. Name of the ACGME-accredited Sponsoring Institution 2. Date(s) of the statement of commitment falling within five years of the current date 3. Explicit reference(s) to the Sponsoring Institution's commitment of necessary financial support for *all* of the areas specified (i.e., "administrative, educational, financial, human, and clinical resources") 4. Inclusion of the Sponsoring Institution's GME mission statement 5. Signatures of (a) the DIO; (b) a representative of the Sponsoring Institution's senior administration; and (c) a representative of the governing body. The printed name, title(s), and role(s) should appear with each signature. If one individual holds more than one of the roles of the required signatories, each of the roles should be separately identified with the signature (e.g., "Dr. Jane Smith, Designated Institutional Official, Governing Body Representative"). |
| What does the IRC expect from the GME mission statement? [Institutional Requirement: I.A.7.(a); Common Program Requirement: IV.A.1.] | This requirement aligns with the Common Program Requirement for an institutional mission that informs the accredited programs' aims and development. The requirement is intended to ensure the Sponsoring Institution has developed a mission relevant to GME. When completing the Institutional Self-Study, the self-study team should evaluate institutional performance related to the Sponsoring Institution's GME mission. |
| Can a DIO have multiple roles as a voting member of a GMEC? | An individual may serve on a GMEC as DIO, as a representative program director, as the individual responsible for quality improvement or patient safety, and/or (in the case of Sponsoring Institutions with one ACGME-accredited program) as the |

| Question | Answer |
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| *[Institutional Requirements: I.B.1.a)-I.B.1.b).(6)]* | individual from a department other than that of the program specialty. It should be apparent from a Sponsoring Institution's records (including the GMEC's voting membership list and meeting minutes) which individuals meet one or more of the minimum membership requirements. |
| What is the right operating structure for a GMEC and its subcommittees?<br><br>*[Institutional Requirements: I.B.2.a); I.B.4.b).(2)]* | A GMEC may have permanent and/or ad hoc subcommittees, or may function without subcommittees. If a GMEC has an executive committee, it is assumed the executive committee fulfills required GMEC responsibilities and therefore counts as a subcommittee of the GMEC under the requirements. If there are permanent and/or ad hoc subcommittees, the Sponsoring Institution should describe them in its ADS Annual Update and should clarify whether each fulfills required GMEC responsibilities [*see Institutional Requirements I.B.4.-6.*]. For each subcommittee that fulfills required GMEC responsibilities, it is expected that the Sponsoring Institution can document inclusion of a peer-selected resident/fellow.<br><br>It is expected that Program Evaluation Committees (PECs) and Clinical Competency Committees (CCCs) operate as program-level committees. [See Common Program Requirements V.A.3. and V.C.1.] To ensure that information about individual residents' or fellows' performance is not shared with GMEC members (e.g., peer-selected residents/fellows) who should not have access, a program's CCC should not function as a subcommittee of the GMEC. While the IRC does not expect PECs to report to the GMEC, it may be appropriate to facilitate required oversight of ACGME-accredited programs' Annual Program Evaluations. |
| What are the specific expectations for a minimum of one GMEC meeting every quarter during each academic year? What is the specific expectation for new Sponsoring Institutions when providing GMEC minutes in the Sponsor Application?<br><br>*[Institutional Requirement: I.B.3.]* | The academic year is from July 1 to June 30, and comprises four quarters which begin July 1, October 1, January 1, and April 1. During each quarter, the GMEC must meet at least once. GMEC meeting minutes must specify the date of each meeting.<br><br>For new Sponsoring Institutions, the minutes of at least one GMEC meeting must be provided in the application. Once the first meeting of a GMEC occurs, the GMEC is expected to meet at least once in each subsequent quarter. |

| Question | Answer |
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| How should GMEC meeting minutes be annotated?<br><br>*[Institutional Requirement: I.B.3.b)]* | GMEC meeting minutes submitted for the IRC's review must clearly document execution of required functions and responsibilities. When submitting GMEC meeting minutes to the ACGME, Sponsoring Institutions are asked to annotate those minutes, which is to say that a reference to a specific Institutional Requirement should accompany each GMEC action that fulfills that requirement. Ideally, annotations should be easy to identify (e.g., in bold type); they may be embedded in the text or placed in a column running next to the text. Appropriate annotations include references to Institutional Requirements in the range of I.B.4. to I.B.6. |
| How should the GMEC oversee programs' implementation of policies and procedures governing vacations and leaves of absence for residents and fellows?<br><br>*[Institutional Requirement: I.B.4.a).(5)]* | The GMEC is responsible for institutional oversight of programs' implementation of vacation and leave policies, including implementation of terms specified in Institutional Requirements IV.H.1.a)-g). This may include the accessibility and use of resident/fellow benefits, based on aggregated information without identifying individual instances of vacations or leaves of absence to the GMEC. The IRC will not cite Sponsoring Institutions for GMEC oversight of vacation and leave policies before July 1, 2023. |
| What is the GMEC's role in ensuring that patient safety summary reports are provided and is there particular information that should be included?<br><br>*[Institutional Requirement: I.B.4.a).(7)]* | At minimum, the GMEC must ensure that summary information of patient safety reports is being provided to residents, fellows, faculty members, and other clinical staff members. The Sponsoring Institution has discretion to determine what type(s) of patient safety summary information is provided. To demonstrate compliance with this requirement, meeting minutes of the GMEC should document verification that summary information is provided at least annually. |
| What are a GMEC's responsibilities and how does it demonstrate it is fulfilling them?<br><br>*[Institutional Requirements: I.B.4.-6.]* | As specified in Institutional Requirements I.B.4.-6., the GMEC's responsibilities include: (1) oversight of institutional and program accreditation; (2) review and approval of various items specified in the Institutional Requirements; and, (3) monitoring of institutional and program performance. "Oversight" includes routine monitoring of institutional and program accreditation, as well as the formalized Annual Institutional Review (AIR) and Special Review processes. There are activities that must be documented in GMEC meeting minutes *at least annually*. These include: |

| Question | Answer |
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|  | (1) Oversight of institutional and program accreditation and recognition outcomes [I.B.4.a).(1)]<br>(2) Oversight of Annual Program Evaluations and Self-Studies [I.B.4.a).(4)]<br>(3) Review and approval of recommendations to the Sponsoring Institution's administration regarding stipends and benefits [I.B.4.b).(3)]<br>(4) Oversight of the AIR and resulting action plans [I.B.5., I.B.5.b).(2)]<br><br>Other GMEC responsibilities for oversight, review, and approval should be documented as they are fulfilled. For new Sponsoring Institutions, it is expected that the GMEC has demonstrated review and approval of stipend/benefit recommendations in meeting minutes included in the Sponsor Application. GMEC meeting minutes should reflect the GMEC's approval of any of the specific actions enumerated in Institutional Requirements I.B.4.b).(1)-(15). For example, if required institutional GME policies and procedures are revised, the GMEC should document review and approval of any revisions. After a Special Review (I.B.6.), the GMEC's meeting minutes should document monitoring of outcomes under its Special Review protocol. GMEC responsibilities for review can be reflected in a number of ways. It is expected that GMEC meeting minutes will record actions such as approvals, AIRs, and Special Review monitoring with precise language (e.g., "approved").<br><br>A Sponsoring Institution that has one or more subcommittees of the GMEC must ensure that subcommittee actions fulfilling required GMEC responsibilities are reviewed and approved by the GMEC. The GMEC should document subcommittee oversight, review, and approval of such subcommittee actions in meeting minutes. |
| What is meant by "resident/fellow stipends and benefits"?<br><br>*[Institutional Requirement: I.B.4.b).(3)]* | "Stipends" is synonymous with "salaries" for the purposes of this requirement. Resident/fellow benefits include terms of the residents'/fellows' appointments, such as health insurance. Benefits may also include one-time payments (sometimes also called "stipends") to be used by residents/fellows for educational purposes, such as travel to attend professional meetings. |

| Question | Answer |
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| What is considered a major change to an ACGME-accredited program for GMEC oversight?<br><br>*[Institutional Requirement: I.B.4.b).(6)]* | Examples of major changes to programs include changes to curriculum, resident/fellow assignments (e.g., rotations), program length, or participating sites that have a substantial impact on resident/fellow education. |
| What is the difference between an AIR and an Annual Program Evaluation? Does a Sponsoring Institution without any ACGME-accredited programs need to complete an AIR?<br><br>*[Institutional Requirement: I.B.5.;*<br>*Common Program Requirements: V.A.3. and V.C.1.]* | Completion of the AIR is a responsibility of the Sponsoring Institution, in contrast with Annual Program Evaluations, which are conducted and documented by PECs. While information from Annual Program Evaluations may be used as performance indicators for a Sponsoring Institution's AIR, the executive summary of the AIR should reflect institutional accreditation oversight that is distinct from program oversight. Requirements for the AIR apply to all Sponsoring Institutions, including those that have one ACGME-accredited program and those that have no programs.<br><br>At least annually, the GMEC's meeting minutes should document the GMEC's oversight of Annual Program Evaluations (and Self-Studies), as well as AIRs (and their resulting action plans) [see FAQ above concerning Institutional Requirements I.B.4-6.]. |
| When should the GMEC complete a Special Review? How often should the GMEC monitor outcomes?<br><br>*[Institutional Requirements: I.B.6.a)-b)]* | The GMEC is expected to establish criteria that will be used to identify underperforming programs. At a minimum, the criteria must identify programs with ACGME accreditation statuses of Initial Accreditation with Warning or Continued Accreditation with Warning, and those with adverse ACGME accreditation statuses. It is expected that the GMEC will define additional criteria to measure program underperformance beyond accreditation statuses. When a program meets one or more underperformance criteria, the GMEC is expected to initiate a Special Review.<br><br>If the GMEC initiates a Special Review due to a program's accreditation status, it is expected that the report of the Special Review report will include timelines, and that this will be developed in advance of the subsequent accreditation review by the relevant ACGME specialty Review Committee. |

| Question | Answer |
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|  | The frequency of GMEC monitoring of outcomes of a Special Review will depend on the quality improvement goals, corrective actions, timelines, and process for GMEC monitoring of outcomes. A timeline for achievement of quality improvement goals, corrective actions, and GMEC monitoring should be included in the Special Review report. |
| **Institutional Resources** | |
| What is an appropriate Resident/Fellow Forum for a Sponsoring Institution with programs that are geographically distant from other programs?<br><br>*[Institutional Requirements: II.C.-II.C.2.*] | A Sponsoring Institution with more than one sponsored program must have a Sponsoring Institution-wide forum where all residents and fellows can communicate and exchange information with other residents and fellows in the Sponsoring Institution, regardless of location. The forum may provide opportunities to communicate and exchange information in an in-person or remote format. A Sponsoring Institution may provide site-specific communication resources to supplement the required Sponsoring Institution-wide forum. |
| What is meant by "ready access to electronic medical literature databases and specialty-/subspecialty-specific and other appropriate full-text reference material"?<br><br>*[Institutional Requirement: II.E.2.]* | Sponsoring Institutions are expected to provide access to medical literature that supports patient care and education in compliance with ACGME requirements. Access to medical literature cannot be solely restricted to physical locations with limited hours. Access to full-text reference materials may be provided online or in print, and may be supported by processes such as interlibrary loans. |
| **The Learning and Working Environment** | |
| What opportunities should residents/fellows and faculty members have for raising concerns and providing feedback confidentially to their Sponsoring Institution?<br><br>*[Institutional Requirement: III.A.]* | Sponsoring Institutions should ensure that institutional mechanisms for residents/fellows and faculty members to raise concerns confidentially do not rely solely on individuals who have roles in the Sponsoring Institution's programs. |
| Do reports from the program director(s) and/or coordinator(s) to the Sponsoring Institution regarding work hour violations satisfy Institutional Requirements addressing | The Sponsoring Institution must oversee resident/fellow clinical and educational work hours in each ACGME-accredited program independently of the program's monitoring process(es). It is not sufficient for institutional oversight process(es) to rely solely on reports from program directors and/or coordinators to evaluate compliance |

| Question | Answer |
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| the oversight of resident and fellow clinical and educational work hours?<br><br>*[Institutional Requirement: III.B.5.a).(1)]* | with ACGME requirements addressing resident/fellow clinical and educational work hour compliance. |
| Should the GMEC be involved in the oversight of resident/fellow clinical and educational work hours?<br><br>*[Institutional Requirement: III.B.5.a).(1)]* | A process undertaken by the GMEC that documents regular, independent oversight of the clinical and educational work hours in each ACGME-accredited programs such as through a GMEC subcommittee, is an example of an activity that supports institutional compliance with this requirement. GMEC oversight of resident/fellow clinical and educational work hour compliance may contribute to fulfillment of oversight responsibility for the quality of the GME learning and working environment. |
| Are all faculty members required to complete education in fatigue mitigation?<br><br>*[Institutional Requirement: III.B.5.a).(3); Common Program Requirement: VI.D.1.a)]* | The ACGME Common Program Requirements specify that programs must educate all faculty members to recognize signs of fatigue and sleep deprivation. The type of education in fatigue mitigation may vary depending on faculty members' roles in residency/fellowship programs. The Sponsoring Institution may demonstrate oversight by confirming the availability of education to all faculty members that is appropriate to their respective roles in ACGME-accredited programs. |
| How does a Sponsoring Institution provide safe transportation options for residents/fellows?<br><br>*[Institutional Requirement: III.B.7.d).(3)]* | Safe transportation options for residents/fellows are essential to ensuring a healthy and safe educational environment. At a minimum, the Sponsoring Institution should demonstrate that it facilitates the safe transportation of residents and fellows, and that residents and fellows are aware of options to utilize when they are fatigued (e.g., reimbursement for transportation, available call rooms). Specific options may vary depending on the types and locations of resident/fellow assignments and available modes of transportation. |
| What would be required for clean and safe refrigeration for human milk?<br><br>*[Institutional Requirement: III.B.7.d).(4)]* | To ensure the safety and security of expressed human milk, options for clean and safe refrigeration should not allow refrigeration resources that are shared with patients or visitors. Examples of options for clean and safe refrigeration include secure staff refrigerators or lockers that accommodate thermoelectric mini-refrigerators or human milk cooling bags. |
| What are practices that focus on ongoing, mission-driven, systematic recruitment and | A variety of institutional practices could support and promote the recruitment and retention of a diverse and inclusive GME workforce. The Sponsoring Institution may |

| Question | Answer |
|---|---|
| retention of a diverse and inclusive GME workforce?<br><br>*[Institutional Requirement: III.B.8.]* | wish to consider ways to engage with communities beyond GME to build professional pathways that begin at early stages of education. |
| **Institutional GME Policies and Procedures** | |
| Should the resident/fellow contract or agreement of appointment include additional items or references related to Osteopathic Recognition, if applicable?<br><br>*[Institutional Requirement: IV.C.]* | The contract or agreement of appointment for a resident/fellow must include or provide a reference to the resident's/fellow's responsibilities in the program. Responsibilities of residents/fellows that pertain to their participation in a program with ACGME Osteopathic Recognition should be reflected in the contract or agreement of appointment. |
| Should Sponsoring Institutions notify residents/fellows if there is a change to tail coverage?<br><br>*[Institutional Requirement: IV.F.2.b)]* | Yes. Sponsoring institutions must ensure that residents and fellows are aware of substantial changes to their professional liability coverage. This includes coverage for claims reported or filed after completion of the program(s), if the alleged acts or omissions of a resident/fellow are within the scope of the program(s) (commonly called "tail coverage"). |
| Do institutional policies for resident/fellow leaves of absence address needs for continuous or intermittent leaves of absence?<br><br>*[Institutional Requirement: IV.H.1.]* | Required elements of institutional policies for vacations and leaves of absence pertain to both continuous and intermittent leaves of absence. |
| Can vacation and other pay sources be used to support residents'/fellows' salary during leaves of absence?<br><br>*[Institutional Requirement: IV.H.1.b)-c)]* | Sponsoring Institutions may use vacation and other pay sources to provide paid time off during leaves of absence, provided that doing so is consistent with institutional policy and applicable laws, and that one week of paid time off is reserved for use outside of the first six weeks of leave. The IRC will not cite Sponsoring Institutions for new elements of vacation and leave policies described in Institutional Requirements IV.H.1.a)-f) before July 1, 2023. |
| Is there a timeframe within which residents/fellows must use the week of paid time off that is reserved for use outside of the | The reserved one week of paid time off (outside the first six weeks of approved medical, parental, and caregiver leaves of absence) is to be available within the appointment year(s) in which the leave is taken. It is not required that this reserved |

| Question | Answer |
|---|---|
| first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken?<br><br>*[Institutional Requirement: IV.H.1.c)]* | week carry over into subsequent years of an individual's educational program. The IRC will not cite Sponsoring Institutions for elements of vacation and leave policies described in Institutional Requirements IV.H.1.a)-f) before July 1, 2023. |
| How should the Sponsoring Institution ensure that residents and fellows are provided with access to confidential counseling and behavioral health services?<br><br>*[Institutional Requirement: IV.I.1.]* | Residents and fellows should know how to access confidential counseling and other behavioral health services that are appropriate to their needs (e.g., routine, urgent, or emergent) and circumstances. The Sponsoring Institution is responsible for fulfilling an essential role in ensuring that services addressing urgent and emergent mental and behavioral health needs are available to all residents/fellows at all times (24/7). |

# Osteopathic Recognition Requirements

ACGME-approved focused revision: September 27, 2020; effective July 1, 2021
Editorial Revision: Name of Osteopathic Recognition Committee updated July 2021

# Contents

## Osteopathic Recognition Requirements

Introduction

Int.A.          Osteopathic Recognition may be conferred by the Osteopathic Recognition Committee upon an ACGME-accredited graduate medical education program providing requisite education in Osteopathic Principles and Practice (OPP). (Core)*

Int.B.          OPP refers to a philosophical and practical approach to patient management and treatment, including osteopathic manipulative treatment (OMT), based on an understanding of body unity, self-healing and self-regulatory mechanisms, and the interrelationship of structure and function. (Core)

Int.C.          OPP further defines the conceptual understanding and practical application of the distinct behavioral, philosophical, and procedural aspects of clinical practice related to the four tenets of osteopathic medicine: (Core)

Int.C.1.              the body is a unit; the person is a unit of body, mind, and spirit; (Core)

Int.C.2.              the body is capable of self-regulation, self-healing, and health maintenance; (Core)

Int.C.3.              structure and function are reciprocally interrelated; and, (Core)

Int.C.4.              rational treatment is based upon an understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function. (Core)

I.          Osteopathic Program Personnel

I.A.          Director of Osteopathic Education

I.A.1.          The program must have a Director of Osteopathic Education who is responsible for leading the osteopathic education in the program. (Core)

I.A.1.a)          The Director of Osteopathic Education must have sufficient time and availability to fulfill the responsibilities of the position based on program size and configuration. (Core)

I.A.1.b)          Qualifications of the Director of Osteopathic Education must include:

I.A.1.b).(1)          requisite osteopathic expertise and documented educational and administrative experience acceptable to the Recognition Committee; (Core)

I.A.1.b).(2)          certification through an American Osteopathic Association (AOA) specialty certifying board, or qualifications judged acceptable to the Recognition Committee; (Core)

I.A.1.b).(3)  current medical licensure and maintenance of clinical skills through provision of direct patient care; and, (Core)

I.A.1.b).(4)  ability to teach and assess OPP. (Core)

I.A.2.  The Director of Osteopathic Education must be the program director or another member of the program faculty. (Core)

I.A.3.  The Director of Osteopathic Education must be a member of the core osteopathic faculty. (Core)

I.A.4.  The Director of Osteopathic Education's responsibilities must include: (Core)

I.A.4.a)  administration and maintenance of the educational environment conducive to educating residents in OPP and the ACGME Competencies; (Core)

I.A.4.b)  development of the OPP curriculum; and, (Core)

I.A.4.c)  development of the OPP evaluation system. (Core)

I.A.5.  The Director of Osteopathic Education must teach designated osteopathic residents the application of OPP. (Core)

I.A.6.  The Director of Osteopathic Education must:

I.A.6.a)  administer and maintain an educational environment conducive to educating residents in OPP and the ACGME Competencies; (Core)

I.A.6.b)  engage in osteopathic professional development applicable to his/her responsibilities as an educational leader; (Core)

I.A.6.c)  oversee and ensure the quality of osteopathic didactic and clinical education at all participating sites; (Core)

I.A.6.d)  designate one osteopathic faculty member, at each participating site where osteopathic education occurs in the clinical learning environment, as the osteopathic site director who is accountable for the supervision of designated osteopathic residents and the osteopathic clinical education provided at the site. (Core)

I.A.6.d).(1)  An osteopathic site director must provide clinical services at the identified site. (Core)

I.A.6.e)  approve the selection and continued participation of osteopathic faculty members, as appropriate; (Core)

I.A.6.f)  prepare and submit all information required and requested by the ACGME; (Core)

I.A.6.g)                  advise residents with respect to osteopathic professional development; and, (Core)

I.A.6.h)                  meet all requirements of an osteopathic faculty member. (Core)

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Background and Intent: The decision of a program to pursue Osteopathic Recognition carries with it a responsibility to provide the leadership necessary for the osteopathic curriculum to succeed. A physician must be designated to serve as the leader responsible for creating the osteopathic learning environment, and ensuring the Osteopathic Recognition Requirements are met. While local titles for this leader may vary, this individual will be recognized in the ACGME's Accreditation Data System (ADS) as the Director of Osteopathic Education and will serve as the primary point of communication with the program regarding the osteopathic curriculum. Any qualified member of the osteopathic faculty may be appointed as the Director of Osteopathic Education, including the program director. The certification requirement for the Director of Osteopathic Education does not mandate that board certification must be in the same specialty as the program.

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I.B.                  Osteopathic Faculty

*Philosophy: Osteopathic faculty members are a foundational element of Osteopathic Recognition. They provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of osteopathic care. They are the role models for the next generation of physicians, demonstrating compassion, commitment to excellence in teaching and patient care, and a dedication to lifelong learning. Osteopathic faculty members foster the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach Osteopathic Principles and Practice.*

*Osteopathic faculty members provide appropriate levels of supervision to promote patient safety. They create a positive osteopathic learning environment through professional actions and attention to well-being of residents and themselves.*

I.B.1.                  Osteopathic faculty members must, through prior education and certification, be able to supervise the performance of osteopathic manipulative medicine (OMM) in the clinical setting. (Core)

I.B.2.                  Osteopathic faculty members must:

I.B.2.a)                  be certified by an AOA specialty certifying board and/or a member board of the American Board of Medical Specialties (ABMS), or possess qualifications judged as acceptable by the Recognition Committee; and, (Core)

I.B.2.b)                  have current medical licensure. (Core)

I.B.3.                  The program must maintain a sufficient number of osteopathic faculty members. (Core)

I.B.4.                    Osteopathic faculty members must:

I.B.4.a)                          annually participate in a structured faculty development program that includes OPP; (Core)

I.B.4.a).(1)                              This program must include ongoing education addressing evaluation and assessment in competency-based medical education. (Core)

I.B.4.b)                          evaluate designated osteopathic residents' application of OPP through direct observation of patient encounters; and, (Core)

I.B.4.c)                          actively participate in organized clinical discussions, rounds, journal clubs, or conferences, for designated osteopathic residents, with specific integration of OPP, including OMT. (Core)

> Background and Intent: The decision of a program to be recognized for delivering osteopathic education carries with it a responsibility to select and appoint faculty members committed to the success of the osteopathic curriculum. Faculty members assist the Director of Osteopathic Education in a variety of roles and to varying degrees to ensure the success of the designated osteopathic residents, inclusive of the requisite education in OPP and training necessary to develop and apply OMT. While local titles may vary, faculty members participating in delivery of the osteopathic curriculum will be designated in ADS as "osteopathic faculty," regardless of medical degree (DO, MD, etc.). The certification requirement for osteopathic faculty members does not mandate that the board certification must be in the same specialty as that of the program. "Osteopathic faculty" refers collectively to the physicians responsible for educating residents participating in a program with Osteopathic Recognition. The term "osteopathic faculty" does not imply or require salary support.

I.C.               Core Osteopathic Faculty

I.C.1.                  Core osteopathic faculty member(s) must:

I.C.1.a)                       assist in the development of the OPP curriculum; (Core)

I.C.1.b)                       assist in the development of the OPP evaluation system; and, (Core)

I.C.1.c)                       teach the application of OPP. (Core)

I.C.2.                  Core osteopathic faculty members must:

I.C.2.a)                       be board certified through an AOA specialty certifying board; or, (Core)

I.C.2.b)                       possess qualifications judged as acceptable by the Recognition Committee. (Core)

I.C.3.                  In addition to the Director of Osteopathic Education, the program must have at least one additional core osteopathic faculty member. (Core)

I.C.4.          Core osteopathic faculty members must meet all osteopathic faculty member requirements. [Core]

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Background and Intent: The decision of a program to be recognized for delivering osteopathic education carries with it a responsibility to select and appoint faculty members committed to the success of the osteopathic curriculum. Such responsibilities include resident formative assessment and involvement with requisite education in OPP and training necessary to develop and apply OMT. Osteopathic core faculty members assume a heightened level of OPP knowledge and skill. In most cases, core osteopathic faculty members will hold a Degree of Osteopathic Medicine, but it is recognized that physicians with other medical degrees are likely to possess the necessary knowledge and skills in the future. The certification requirement for core osteopathic faculty members does not mandate that the board certification must be in the same specialty as that of the program. The term "osteopathic core faculty" does not imply or require an academic appointment or salary support.

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II.       Designated Osteopathic Resident Appointments

II.A.         Each program must have at least one designated osteopathic resident per program year, averaged over three years. [Core]

II.A.1.          Programs must designate, in ADS, the residents who will formally receive osteopathic education. [Core]

II.B.         Prior to entering a designated osteopathic position, applicants must have sufficient background and/or instruction in osteopathic philosophy and techniques in manipulative medicine to prepare them to engage in the curriculum of the program, to include: [Core]

II.B.1.          osteopathic philosophy, history, terminology, and code of ethics; [Core]

II.B.2.          anatomy and physiology related to osteopathic medicine; [Core]

II.B.3.          indications, contraindications, and safety issues associated with the use of OMT; and, [Core]

II.B.4.          palpatory diagnosis, osteopathic structural examination, and OMT. [Core]

II.C.         The program must have a policy that outlines the eligibility requirements for appointment, based on the type of medical school from which the applicant graduated, as outlined in Common Program Requirements (Residency) III.A.1.a)-III.A.1.b).(2). The policy must clearly identify what is required of the applicant prior to entering a designated osteopathic position in an ACGME-accredited program with Osteopathic Recognition. [Core]

II.C.1.          The policy must include requirements for each medical school type. [Core]

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Background and Intent: Osteopathic Recognition provides opportunity to physicians, including those who did not graduate from an accredited college of osteopathic medicine, to obtain education in OPP they can subsequently apply to patient care.

This opportunity requires foundational education in OPP to prepare for success as a resident in a program with Osteopathic Recognition.

Programs with Osteopathic Recognition are asked to describe their expectations for foundational education in order to increase the chance of resident success. The breadth and depth of such foundational education will reflect the resources, expertise, and culture of the program.

Establishing resident eligibility requirements does not imply a program must accept an applicant. Programs will follow their usual policies and procedures when undertaking a review of applicants and accept those they deem most qualified.

The hope is that by establishing appropriate foundational requirements, candidates will be more easily recognized as qualified for participation in a program with Osteopathic Recognition.

III.     Osteopathic Educational Program

The curriculum for designated osteopathic residents must integrate OPP into each of the ACGME Competencies. [Core]

III.A.          Patient Care and Procedural Skills

Each resident must demonstrate the ability to:

III.A.1.              approach the patient with recognition of the entire clinical context, incorporate osteopathic principles, including the four tenets, and use the relationship between structure and function to promote health; [Core]

III.A.2.              use OPP to perform competent physical, neurologic, and structural examinations incorporating analysis of laboratory and radiology results, diagnostic testing, and physical examination as appropriate to his/her specialty; [Core]

III.A.3.              document somatic dysfunction and its treatment as applicable to each patient's care; [Core]

III.A.4.              effectively treat patients and provide medical care that incorporates the osteopathic philosophy; [Core]

III.A.5.              gather accurate, essential information from all sources, including information relevant to OPP; [Core]

III.A.6.              demonstrate a caring attitude that is mindful of cultural sensitivities and patient apprehension concerning touch and palpatory diagnosis; [Core]

III.A.7.              assume increased responsibility for the incorporation of osteopathic concepts into his/her patient management; [Core]

III.A.8.              demonstrate listening skills in interactions with patients, utilizing caring, compassionate behavior and touch (where appropriate); [Core]

III.A.9.        competently perform osteopathic evaluation and treatment appropriate to his/her medical specialty; and, (Core)

III.A.10.      provide health care services appropriate for his/her specialty consistent with osteopathic philosophy, including preventative medicine and health promotion based on current scientific evidence. (Core)

III.B.        Medical Knowledge

          Residents must:

III.B.1.        demonstrate the ability to integrate knowledge of accepted standards of OPP in their respective specialty areas; (Core)

III.B.2.        demonstrate understanding and application of OPP to patient care; (Core)

III.B.3.        demonstrate the treatment of the person rather than symptoms; (Core)

III.B.4.        demonstrate understanding of somatovisceral relationships and the role of the musculoskeletal system in disease as appropriate to their respective specialty; and, (Core)

III.B.5.        perform critical appraisals of literature related to OPP relative to their specialty. (Core)

III.C.        Practice-based Learning and Improvement

          Residents must demonstrate the ability to:

III.C.1.        incorporate literature and research that integrate osteopathic tenets into clinical decision making; (Core)

III.C.2.        critically evaluate their methods of osteopathic clinical practice, integrate evidence-based OPP into patient care, show an understanding of research methods, and improve patient care practices as related to their specialty area; (Core)

III.C.3.        treat patients in a manner consistent with the most up-to-date information on diagnostic and therapeutic effectiveness related to OPP; and, (Core)

III.C.4.        perform self-evaluations of osteopathic practice patterns and practice-based improvement activities using a systematic methodology. (Core)

III.D.        Interpersonal and Communication Skills

          Residents must demonstrate:

III.D.1.        interpersonal and communication skills that enable them to effectively discuss osteopathic concepts and their role in patient care with patients, families, and other members of health care teams as appropriate for their specialty area; and, (Core)

III.D.2.  appropriate verbal and non-verbal skills (including touch) when communicating with patients, families, and interprofessional collaborative team members. (Core)

III.E.  Professionalism

Residents must:

III.E.1.  demonstrate awareness of and proper attention to issues of culture, religion, age, gender, sexual orientation, and mental and physical disabilities as they may influence a patient's perception of touch within the context of OPP; (Core)

III.E.2.  treat the terminally ill with compassion in management of pain, palliative care, appropriate touch, and preparation for death; (Core)

III.E.3.  demonstrate an increased understanding of conflicts of interest inherent to osteopathic clinical practice and the appropriate responses to societal, community, and health care industry pressures; and, (Core)

III.E.4.  utilize caring, compassionate behavior and appropriate touch with patients as related to their specialty area. (Core)

III.F.  Systems-based Practice

Residents must:

III.F.1.  demonstrate an understanding of the role of osteopathic clinical practice in health care delivery systems, provide effective and qualitative osteopathic patient care within the system, and practice cost-effective medicine; and, (Core)

III.F.2.  advocate for quality osteopathic health care on behalf of their patients, and assist them in their interactions with the complexities of the medical system. (Core)

IV.  Osteopathic Learning Environment

Programs with Osteopathic Recognition must create a learning environment that integrates and promotes the application of OPP throughout the duration of the educational program. (Core)

IV.A.  Experiences

Programs must:

IV.A.1.  provide residents with instruction in the application of OPP; (Core)

IV.A.2.  embed the four tenets of osteopathic medicine into the educational program (see Int.C.); (Core)

IV.A.3.      provide structured didactic activities that integrate OPP; (Core)

IV.A.3.a)      Designated osteopathic residents must be provided with protected time to participate in these didactic activities. (Core)

IV.A.4.      provide learning activities to advance the procedural skills acquisition in OMM for both designated osteopathic residents and osteopathic faculty members; (Core)

IV.A.5.      ensure designated osteopathic residents provide osteopathic patient care in a variety of clinical settings, to ensure a broad education experience; (Core)

IV.A.6.      ensure designated osteopathic residents teach OPP; (Core)

IV.A.6.a)      Such opportunities could occur through resident-delivered OPP didactic lectures, hands-on OMM workshops, and/or resident-led journal clubs; (Detail)†

IV.A.7.      create a learning environment that supports and encourages osteopathic scholarly activity by designated osteopathic residents and osteopathic faculty members to advance OPP; (Core)

IV.A.8.      ensure that osteopathic faculty members collectively produce at least two osteopathic scholarly activities annually, averaged over a five-year period; (Core)

IV.A.9.      ensure that each designated osteopathic resident produces at least one osteopathic scholarly activity prior to graduating from the program; and, (Core)

IV.A.10.      provide learning activities and communication that promote understanding of OPP among the interprofessional team. (Core)

IV.B.      Resources

IV.B.1.      Osteopathic faculty members, including the Director of Osteopathic Education and core osteopathic faculty members, may be shared between programs with Osteopathic Recognition. (Core)

IV.B.1.a)      A written plan must be provided detailing how shared faculty members' time with each program and participating site will be divided, and oversight be maintained, so as not to compromise the osteopathic education of designated osteopathic residents in any involved program. (Core)

IV.B.2.      The program must:

IV.B.2.a)      provide a variety of learning resources to support osteopathic medical education, including reference material pertaining to OMM and OPP integration into patient care; (Core)

IV.B.2.a).(1)      This must include access to examination tables suitable for OMT; and, (Core)

IV.B.2.a).(2)      This must include facilities for osteopathic clinical and didactic activities. (Core)

IV.B.2.b)      provide resources to support osteopathic scholarly activity by designated osteopathic residents and osteopathic faculty members; and, (Core)

IV.B.2.c)      ensure the annual availability of structured faculty development for osteopathic faculty members that includes OPP and ongoing education addressing evaluation and assessment in competency-based medical education. (Core)

IV.B.3.      Programs should participate in a community of learning that promotes the continuum of osteopathic medical education. (Core)

V.      Osteopathic Evaluation

V.A.      Designated Osteopathic Resident Evaluation

The program must provide assessment of the resident in application of OPP in each of the ACGME Competencies. (Core)

V.A.1.      Clinical Competency Committee

V.A.1.a)      The Director of Osteopathic Education or an osteopathic faculty member designee should be a member of the program's Clinical Competency Committee (CCC). (Core)

V.A.1.b)      The program's CCC or a sub-committee of the CCC must review the progress of all designated osteopathic residents in the program as it relates to OPP. (Core)

V.A.1.c)      The CCC or a sub-committee of the CCC must:

V.A.1.c).(1)      include at least two osteopathic faculty members, which may include the Director of Osteopathic Education; (Core)

V.A.1.c).(2)      review all designated osteopathic residents' evaluations semi-annually as these relate to the Osteopathic Recognition Milestones; (Core)

V.A.1.c).(3)      prepare and ensure the reporting of Osteopathic Recognition Milestones evaluations for each designated

osteopathic resident semi-annually to the ACGME; and, (Core)

V.A.1.c).(4)    advise the program director and Director of Osteopathic Education regarding resident progress, including promotion, remediation, and dismissal from a designated osteopathic position. (Core)

V.A.2.    Formative Evaluation

V.A.2.a)    Osteopathic faculty members must evaluate and document designated osteopathic residents' competence in OPP in each of the ACGME Competencies. (Core)

V.A.2.b)    Timing and frequency of the evaluation must be consistent with the type of assignment, which must include: (Core)

V.A.2.b).(1)    clinical rotations; (Core)

V.A.2.b).(2)    clinical experiences; and, (Core)

V.A.2.b).(3)    educational activities. (Core)

V.A.2.c)    Evaluations of these assignments must assess resident performance longitudinally. This may not exclusively occur through single patient encounter assessments. (Core)

V.A.2.d)    The period of evaluation should not exceed three months. (Core)

V.A.2.e)    During clinical rotations and clinical experiences, the application of OPP, as appropriate to the specialty, must include direct observation of patient encounters and a review of the documented assessment and plan. (Core)

V.A.2.f)    Designated osteopathic residents must receive an evaluation regarding their integration of OPP into scholarly activity. (Core)

V.A.2.g)    There must be an evaluation system overseen by the Director of Osteopathic Education, to determine when a resident has obtained the necessary skills to perform OMT under supervision, as a component of patient care. (Core)

V.A.2.h)    There must be objective formative assessment of osteopathic medical knowledge and procedural skills. This should include: (Core)

V.A.2.h).(1)    a standardized assessment of OPP knowledge; and, (Core)

V.A.2.h).(2)    an assessment of skill proficiency in OMT, as applicable to the specialty. (Core)

Background and Intent: The requirement for objective formative assessment, including standardized assessment of OPP knowledge, is intended to provide osteopathic faculty members and designated osteopathic residents with information that will allow for comparisons within and external to the program about resident progress toward program completion and practice readiness. Standardized assessment of OPP knowledge across all specialties and provision of assessment-derived information that may serve as an indicator of future performance on AOA board certification examinations is aspirational.

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| V.A.2.i) | The Director of Osteopathic Education must provide designated osteopathic residents with documented semi-annual evaluation of performance and progression in the application of OPP in each of the ACGME Competencies, with feedback. (Core) |
| V.A.3. | Final Evaluation |
| V.A.3.a) | The Osteopathic Recognition Milestones must be one of the tools used to ensure designated osteopathic residents are able to practice without supervision upon completion of the program. (Core) |
| V.A.3.b) | The Director of Osteopathic Education must conduct a final evaluation related to completion of the osteopathic education program for each designated osteopathic resident. (Core) |
| V.A.3.c) | The final evaluation must: |
| V.A.3.c).(1) | become part of the designated osteopathic resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core) |
| V.A.3.c).(2) | document the resident's performance related to the application of OPP in each of the ACGME Competencies during the final period of education; and, (Core) |
| V.A.3.c).(3) | verify that the designated osteopathic resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice and to apply OPP to patient care. (Core) |
| V.A.3.c).(3).(a) | Transitional and preliminary year programs are not required to include verification that designated osteopathic residents have demonstrated sufficient competence to apply OPP to patient care, upon entering practice, without direct supervision. (Detail) |
| V.B. | Osteopathic Faculty Evaluation |
| V.B.1. | At least annually, the Director of Osteopathic Education must evaluate osteopathic faculty member performance as related to the integration of OPP into the educational program. (Core) |

V.B.2.   Evaluation of osteopathic faculty members must include:

V.B.2.a)   annual written confidential evaluations of the faculty members by the designated osteopathic residents or evaluations following completion of rotations or similar educational experiences as related to the integration of OPP; and, [Core]

V.B.2.b)   assessment of the knowledge, application, and promotion of OPP. [Core]

V.C.   Program Evaluation

V.C.1.   Designated osteopathic residents and osteopathic faculty members must have the opportunity to evaluate the osteopathic components of the program confidentially and in writing at least annually. [Core]

V.C.2.   The program must use the results of residents' and faculty members' evaluations of the osteopathic components of the program together with other program evaluation results to improve the program. [Core]

V.C.3.   The program's pass rate for designated osteopathic residents taking the applicable AOA certifying board examination, containing osteopathic content, for the first time during the preceding three years must be 80 percent or higher. [Outcome]‡

V.C.3.a)   Transitional and preliminary year residents are excluded from this requirement. [Detail]

V.C.4.   Residents who enter a designated osteopathic position should complete the program in a designated osteopathic position. [Core]

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**\*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.

# ACGME Recognition for Sponsoring Institutions with Non-Standard Training Programs for J-1 Visa Sponsorship

Definitions:

1.  Non-Standard Training (NST) Program: Clinical training for foreign national physicians in advanced subspecialty programs for which there is no Accreditation Council for Graduate Medical Education (ACGME) accreditation or American Board of Medical Specialties (ABMS) Member Board certification.

2.  NST Trainee: A physician in an NST program who holds a J-1 visa sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG).

3.  Institutional Recognition: An ACGME process for approval of ACGME-accredited Sponsoring Institutions to conduct NST programs. Institutional Recognition is distinct and separate from ACGME accreditation processes.

Purpose:

Recognition of Sponsoring Institutions with NST programs by the ACGME provides a framework for approval and oversight of training opportunities in the United States for physicians whose J-1 visas are sponsored by the ECFMG through the Exchange Visitor Program of the United States Department of State. The ACGME recognizes ACGME-accredited Sponsoring Institutions that offer NST Programs and that demonstrate substantial compliance with the following Recognition Requirements. The recognized Sponsoring Institution bears the responsibility for each NST program and NST trainee under its auspices, for assessment of the impact of NST programs on related ACGME-accredited program(s), and for compliance with regulatory requirements for J-1 participants.

**Recognition Requirements for Sponsoring Institutions with Non-Standard Training Programs
for J-1 Visa Sponsorship**

I.      Sponsoring Institution that Offers Nonstandard Training (NST) Programs

I.A.      Sponsoring Institution

I.A.1.      Each NST program must function under the ultimate authority and oversight of one ACGME-accredited Sponsoring Institution with an institutional accreditation status of Initial Accreditation, Initial Accreditation with Warning, Continued Accreditation, or Continued Accreditation with Warning. (Core)*

I.A.2.      The Sponsoring Institution must ensure the availability of adequate personnel, clinical activities, and other resources for conducting NST programs without adverse impact on the education of residents/fellows in the Sponsoring Institution's ACGME-accredited programs. (Core)

I.A.3.      The Sponsoring Institution must sponsor an ACGME-accredited residency/fellowship program in the most closely related specialty/subspecialty for each NST program. (Core)

I.A.3.a)      The most closely related ACGME-accredited residency/fellowship program must maintain a status of Continued Accreditation or Continued Accreditation with Warning. (Core)

I.A.4.      The Sponsoring Institution must ensure compliance with regulations that govern the participation of sponsors in the Exchange Visitor Program of the United States Department of State. (Core)

I.B.      Designated Institutional Official (DIO)

I.B.1.      The DIO of the ACGME-accredited Sponsoring Institution, in collaboration with the Sponsoring Institution's Graduate Medical Education Committee (GMEC), must have authority and responsibility for the oversight and administration of each of the Sponsoring Institution's NST programs, as well as for ensuring compliance with the Recognition Requirements for Sponsoring Institutions with NST Programs. (Core)

I.B.2.      The DIO must oversee the preparation and submission of all information about the Sponsoring Institution's NST program(s) required and requested by the ACGME. (Core)

I.C.      NST Program Director

I.C.1.      There must be a single NST program director, from among the physician faculty members of the most closely related ACGME-accredited residency/fellowship program, who is responsible for the operation of each NST program. (Core)

I.C.2.  The NST program director must oversee NST trainee supervision, education, and assessment at all participating sites. (Core)

I.D.  GMEC

I.D.1.  The GMEC must review and approve the program description of each NST program within the Sponsoring Institution. (Core)

I.D.1.a)  The program description must specify any qualifications for appointment of the NST program director. (Core)

I.D.2.  The GMEC must review and approve the appointment of each of its NST program directors. (Core)

I.D.3.  At least annually, the GMEC must complete and document an assessment of:

I.D.3.a)  supervision and assessment of NST trainees; and, (Core)

I.D.3.b)  the impact of NST programs on the Sponsoring Institution's ACGME-accredited programs. (Core)

I.E.  Participating Sites in ACGME Accreditation Data System (ADS)

I.E.1.  NST trainees' assignments/rotations must be limited to the participating sites of the most closely related ACGME-accredited program, as identified by the Sponsoring Institution and listed in ADS. (Core)

II.  NST Programs

II.A.  Appointment

II.A.1.  Each NST program must define the prerequisite education and/or training for entry into the NST program. (Core)

II.A.2.  Each NST program must ensure that NST trainees appointed to the NST program meet prerequisites for entry into the NST program. (Core)

II.A.3.  The Sponsoring Institution must ensure that NST trainees are provided with a written agreement outlining the terms and conditions of their appointments. The agreement must directly contain or provide a reference to the following items: (Core)

II.A.3.a)  NST trainee responsibilities, including any requirements for successful completion of the NST program; (Core)

II.A.3.b)  duration of training; (Core)

II.A.3.c)  financial arrangements related to the NST trainee; (Core)

II.A.3.d)  grievance and due process; (Core)

II.A.3.e)　　　　　　professional liability coverage, including a summary of pertinent information regarding coverage; (Core)

II.A.3.f)　　　　　　the availability of health insurance benefits for NST trainees and their eligible dependents; and, (Core)

II.A.3.g)　　　　　　vacation, and leave(s) of absence for NST trainee(s), including medical, parental, and caregiver leave(s) of absence, and compliant with applicable laws. (Core)

II.A.4.　　　　The Sponsoring Institution must monitor each of its NST programs with regard to implementation of terms and conditions of the agreement. (Core)

II.B.　　　Curriculum

II.B.1.　　　　The NST program must make available to NST trainees and faculty members a curriculum that includes: (Core)

II.B.1.a)　　　　　　overall educational goals for the NST programs; (Core)

II.B.1.b)　　　　　　delineation of NST trainee responsibilities for patient care, responsibility for patient management, and supervision during the NST program; and, (Core)

II.B.1.c)　　　　　　a description of required educational experiences, didactic sessions, assessment methods, and procedural experience requirements. (Core)

II.C.　　　Assessment

II.C.1.　　　　Initial and Formative Assessment

II.C.1.a)　　　　　　No later than three months from the NST trainee's starting date in the NST program, each NST program director must complete an initial competence assessment of each NST trainee in the NST program, including an ACGME Milestones assessment from the most closely related ACGME-accredited specialty or subspecialty. (Core)

II.C.1.b)　　　　　　A supervising faculty member must be physically present to supervise the NST trainee with all patients until the NST program director has documented the NST trainee's ACGME Milestones achievement as a sufficient basis for delegating progressive authority and responsibility and conditional independence, as assigned by the NST program director and faculty members. (Core)

II.C.1.c)　　　　　　For each NST trainee appointed to an NST program for one year or longer, the NST program director or the NST program director's designee must meet with the NST trainee to review a semi-annual evaluation of the NST trainee's performance. (Core)

II.C.2.          Summative Assessment

Each NST program director must provide a summative evaluation for each NST trainee upon the NST trainee's completion of, or separation from, the NST program. (Core)

II.C.3.          Opportunity to Raise Concerns and Provide Feedback

The Sponsoring Institution and each of its NST programs must provide a learning and working environment in which NST trainees have the opportunity to raise concerns and provide feedback without fear of intimidation or retaliation and in a confidential manner as appropriate. (Core)

II.C.4.          Clinical and Educational Hours of NST Trainees

Clinical and educational hours of NST trainees 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, and clinical responsibilities completed at home. (Core)

II.C.5.          Mandatory Time Free of Clinical and Educational Activities

NST trainees must be scheduled for a minimum of one day in seven free of required clinical and educational responsibilities (when averaged over four weeks). At-home clinical responsibilities cannot be assigned on these free days. (Core)

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**Core Requirements:** Statements that define structure, resource, or process elements essential to every Sponsoring Institution with an NST 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 NST trainees at key stages of their NST program.

**Accreditation Council for Graduate Medical Education**

**Glossary of Terms**

**March 10, 2023**

# ACGME Glossary of Terms

**Accreditation Data System (ADS):** A web-based software system to collect, organize, and maintain information for accreditation and recognition purposes, and a means of communication between the ACGME and Sponsoring Institutions and programs.

**Accreditation status:** The official decision made by a Review Committee based on its review and assessment of a Sponsoring Institution's or program's compliance with the applicable requirements. *See ACGME Policies and Procedures, Policies 19.00-19.300.*

**Adverse action:** An accreditation or recognition action resulting from a Review or Recognition Committee's determination of substantial non-compliance with the applicable Program or Recognition Requirements. *See ACGME Policies and Procedures, Policies 19.10-19.12, 19.70-19.71, 19.90-19.91, 19.100-19.102, 19.500, 22.10-22.12, 22.70-22.71, and 22.80.*

**Alleged egregious event:** The occurrence of an alleged accreditation violation affecting a Sponsoring Institution or program determined by the President and Chief Executive Officer (or designee) of the ACGME to be of sufficient importance and urgency to require a rapid response. *See ACGME Policies and Procedures, Policies 24.00-24.10.*

**Applicant:** An individual invited to interview with a graduate medical education program.

**At-home call (pager call):** Call taken from outside the assigned site. *See Common Program Requirements VI.F.8.-VI.F.8.b).*

**Attending physician:** The single identifiable physician ultimately responsible and accountable for an individual patient's care, who may or may not be responsible for supervising residents or fellows.

**Categorical resident:** A resident who enters a program that begins in the PGY-1 and provides the required education and training to be eligible for specialty board certification.

**Certification:** The official attestation by a specialty certifying board of an individual physician's knowledge and skills relative to the provision of high-quality care in a particular specialty or subspecialty, generally following successful completion of one or more examinations. The ACGME does not provide certification services.

**Citation:** A finding of a Review or Recognition Committee that a Sponsoring Institution or program has failed to comply substantially with a particular accreditation or recognition requirement.

**Clinical Competency Committee (CCC):** A required body comprising three or more members of the active teaching faculty, including at least one core faculty member, that is advisory to the program director and reviews the progress of all residents or fellows in the program. *See Common Program Requirements, Section V.A.3.*

**Clinical and educational work hours:** All clinical and academic activities related to the program: patient care (inpatient and outpatient); administrative duties relative to patient care; the provision for transfer of patient care; time spent on in-house call; time spent on clinical work

done from home; and other scheduled activities, such as conferences. These hours do not include reading, studying, research done from home, and preparation for future cases. Formerly known as "duty hours."

**Clinical Learning Environment Review (CLER) Program:** An ACGME initiative designed to provide US teaching hospitals, medical centers, health systems, and other clinical settings affiliated with ACGME-accredited Sponsoring Institutions with periodic feedback in Focus Areas specific to the safety of the clinical learning environment.

**CLER site visit:** A visit conducted by CLER Field Representative(s) and other representatives, as determined by the ACGME, that includes interviews with faculty members, program directors, residents and/or fellows, participating site personnel, institutional leadership, and other selected staff members, and the review of institutional documentation, as needed, to assess the effectiveness of the Sponsoring Institution and its participating sites in managing the integration of graduate medical education in the six CLER Focus Areas.

**Common Program Requirements:** The ACGME requirements that apply to all specialties and subspecialties within a specific category (see below). These requirements are denoted by bold text within the applicable Program Requirement documents.

> **Common Program Requirements (Residency):** Applicable to all residency programs and transitional year programs.

> **Common Program Requirements (Fellowship):** Applicable to most fellowship programs.

> **Common Program Requirements (One-Year Fellowship):** Applicable to those one-year fellowships that chose to use an abbreviated version of the Common Program Requirements (Fellowship).

> **Common Program Requirements (Post-Doctoral Education Program):** Applicable to post-doctoral programs in a medical or medical-related field. *See also Post-doctoral program in a medical or medical-related field.*

**Complaint:** An allegation that a Sponsoring Institution or program is non-compliant with accreditation or recognition requirements.

**Complement:** The maximum number of residents or fellows approved by a Review Committee per year and/or per program based upon availability of resources.

**Conditional independence:** Graded, progressive responsibility for patient care with defined oversight.

**Core Competencies:** The six domains of educational and clinical knowledge, skills, and attitudes that physicians must develop for independent and autonomous practice of a specialty or subspecialty. These domains are: Patient Care and Procedural Skills; Medical Knowledge; Practice-Based Learning and Improvement; Interpersonal and Communication Skills; Professionalism; and Systems-Based Practice.

> **Competencies:** Common and specialty- or subspecialty-specific knowledge, skills, and attitudes within the Core Competency domains for a particular specialty or subspecialty.

**Cultural humility:** A practice of ongoing self-reflection on how one's own background and the background of others impact teaching, learning, research, creative activity, engagement, leadership, etc.

**Designated institutional official (DIO):** The individual in a Sponsoring Institution who has the authority and responsibility for all of that institution's ACGME-accredited programs.

**Extraordinary circumstance:** A situation or event that significantly alters the ability of a Sponsoring Institution and its programs to support resident/fellow education. *See ACGME Policies and Procedures, Policy 25.00.*

**Faculty:** The group of individuals (both physician and non-physician) assigned to teach and supervise residents/fellows.

> **Core faculty:** *See Common Program Requirement II.B.4.*

**Fellow:** An individual enrolled in an ACGME-accredited fellowship (subspecialty or sub-subspecialty) program who has completed a residency program in a related specialty and/or a fellowship program in a related subspecialty. Note: the term may also refer to other learners by individual institutions or programs.

**Fellowship:** A program that provides advanced education and training in progressive levels of subspecialization following completion of education and training in a primary specialty and, if applicable, a related subspecialty. It is a structured educational activity comprising a series of clinical and/or other learning experiences designed to prepare physicians to enter the unsupervised practice of medicine in a subspecialty or sub-subspecialty.

> **Residency-dependent subspecialty program:** A program required to function with an accredited residency program in its related specialty. The Continued Accreditation of the subspecialty program is dependent on the residency program's maintaining its accreditation. A residency-dependent subspecialty program must be sponsored by the same ACGME-accredited Sponsoring Institution as the associated residency program.

> **Residency-independent subspecialty program:** A fellowship program that is not required to function with an accredited residency program in its related specialty. These subspecialty programs are dependent on an ACGME-accredited Sponsoring Institution. These programs may occur in two circumstances:

>> 1. The program is reliant upon an ACGME-accredited Sponsoring Institution that sponsors programs in more than one specialty and/or subspecialties.

>> 2. The program is reliant upon an ACGME-accredited Sponsoring Institution that sponsors a program or programs in only one subspecialty.

> **Sub-subspecialty program:** A program that provides advanced training in progressive levels of specialization following completion of education and training in both the primary specialty and its related subspecialty. It is a structured educational activity comprising a series of clinical and/or other learning experiences designed to prepare physicians to enter the unsupervised practice of medicine in a sub-subspecialty. Each sub-subspecialty program must be dependent on a related subspecialty program sponsored

by the same ACGME-accredited Sponsoring Institution.

**Final evaluation:** The required overall evaluation to be completed by the program director for every resident or fellow upon completion of a program. May also be referred to as a "summative evaluation."

**Formative evaluation:** Feedback provided as a result of ongoing monitoring of resident/fellow learning and experience that can be used by residents/fellows to improve their knowledge and performance. *See Background and Intent associated with Common Program Requirement V.A.1.*

**Graduate medical education:** The period of didactic and clinical education in a medical specialty, subspecialty, or sub-subspecialty that follows completion of undergraduate medical education (i.e., medical school) and that prepares physicians for the independent practice of medicine in that specialty, subspecialty, or sub-subspecialty. Also referred to as residency or fellowship education.

**In-house call:** Clinical and educational work hours, beyond the scheduled workday, when residents are required to be immediately available within an assigned site, as needed, for clinical responsibilities. In-house call does not include night float, being on call from home, or regularly scheduled overnight duties.

**International medical graduate (IMG):** A graduate from a medical school outside the United States and Canada. IMGs may be citizens of the United States who chose to be educated elsewhere or non-citizens who are admitted to the United States by US Immigration authorities.

**Interprofessional team:** The physicians and other health care professionals, including nurses, pharmacists, case workers, physical therapists, etc., as appropriate, assigned to the delivery of care for an individual patient.

**Letter of Notification (LON):** The official communication from a Review or Recognition Committee that states an action taken by the committee.

**Milestones:** Description of performance levels residents and fellows are expected to demonstrate for skills, knowledge, and behaviors in the six Core Competency domains. "The Milestones" refers to a complete set or the overall ACGME Milestones framework; "milestone(s)" refers to individual items within a set. *See the Milestones section of ACGME website for more information*.

**Moonlighting:** Voluntary, compensated, medically related work performed beyond a resident's or fellow's clinical experience and education hours and additional to the work required for successful completion of the program.

> **External moonlighting:** Voluntary, compensated, medically related work performed outside the site where the resident or fellow is in training and any of its related participating sites.

> **Internal moonlighting:** Voluntary, compensated, medically related work performed within the site where the resident or fellow is in training or at any of its related participating sites.

**Multidisciplinary subspecialty program**: A fellowship is that is co-sponsored by multiple specialties and for which accreditation is overseen by multiple Review Committees.

**Must:** A term used to identify a requirement that is mandatory or done without fail when the requirement is categorized as "Core" or "Outcome."

Note: When a "must" requirement is categorized as "Detail," a program holding a status of Continued Accreditation or Continued Recognition may use alternative or innovative approaches in meeting the associated "Core" requirement(s), where applicable.

**Night float:** A rotation or other structured educational experience designed either to eliminate in-house call or to assist other residents/fellows during the night. Residents/fellows assigned to night float are assigned on-site duty during evening/night shifts, are responsible for admitting or cross-covering patients until morning, and do not have daytime assignments. Such a rotation must have an educational focus.

**Non-standard training (NST) program:** Clinical training for foreign national physicians in advanced subspecialty programs for which there is no ACGME accreditation or American Board of Medical Specialties Member Board certification.

**Non-standard trainee:**
A physician in a non-standard training (NST) program who holds a J-1 visa sponsored by the Educational Commission for Foreign Medical Graduates.

**One day off:** One continuous 24-hour period free from all administrative, clinical, and educational activities. *See the Common Program Requirement FAQs.*

**Participating site:** An organization providing educational experiences or educational assignments/rotations for residents/fellows. *See Background and Intent associated with Common Program Requirement I.A.*

**Pipeline specialties:** Specialties that lead to primary board certification. The net output of physicians over time from the graduate medical education system into clinical practice is determined by the number of positions available in pipeline specialties.

**Post-doctoral program in a medical or medical-related field:** A structured educational activity comprising a series of clinical and/or other learning experiences, designed to train MDs, DOs, and others in a medical or medical-related field. *See ACGME Policies and Procedures, Policy 13.00.*

**Post-graduate year (PGY):** The denotation of residents' or fellows' progress in their residency and/or fellowship education. The PGY does not necessarily correspond to a resident's or fellow's year in an individual program. For example, a fellow who has completed a pediatric residency program and is in the first year of a pediatric endocrinology fellowship would be considered a PGY-4, denoting the three years spent in pediatric residency and the first year of the fellowship.

**Primary clinical site:** The most commonly used facility designated for clinical instruction in the program.

**Program coordinator:** The lead administrative person who assists the program director in accreditation efforts, educational programming, and support of residents/fellows.

**Program director:** The individual designated with authority and accountability for the operation of a residency/fellowship program, including compliance with all applicable program requirements.

**Program Evaluation Committee (PEC):** Group appointed by the program director to conduct program review as needed and the Annual Program Evaluation. *See Common Program Requirements, Section V.C.*

**Progress report:** A report requested of a Sponsoring Institution or program regarding concerns the Review or Recognition Committee had during its regular review of the institution or program. The progress report must be reviewed by the Sponsoring Institution's Graduate Medical Education Committee (GMEC) and must be signed by the designated institutional official (DIO) prior to submission to the Review or Recognition Committee.

**Program Letter of Agreement (PLA):** A written document that addresses graduate medical education responsibilities between an individual accredited program and a site other than the Sponsoring Institution at which residents or fellows have required educational experiences.

**Program year:** Refers to a specific year of a residency or fellowship program; this designation may or may not correspond to an individual resident's or fellow's post-graduate year.

**Psychological safety:** An environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

**Recognition:** Acknowledgment, supplemental to accreditation, for identified elements or categories of a Sponsoring Institution or program.

**Recognition Committee:** A group comprised of volunteers that sets Recognition standards (requirements), provides peer evaluation of Sponsoring Institutions or programs to assess the degree to which these comply with the applicable published Recognition Requirements, and confers a Recognition status on each Sponsoring Institution or program with regard to substantial compliance with those requirements.

**Recognition status:** The official decision made by a Review or Recognition Committee based on its review and assessment of a Sponsoring Institution's or program's compliance with the applicable Recognition Requirements. *See ACGME Policies and Procedures for more information.*

**Requirements (Institutional, Program, and Recognition):**

    **Core Requirements:** Statements that define structure, resource, and 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 comply with Core requirements.

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

**Resident:** An individual enrolled in an ACGME-accredited residency program.

**Residency program:** A structured educational activity comprising a series of clinical and/or other learning experiences in graduate medical education, designed to prepare physicians to enter the unsupervised practice of medicine in a primary specialty. There are two types of residency programs: (a) residency programs available for physician admission immediately upon graduation from a medical school or a college of osteopathic medicine as described in the Institutional Requirements, Section IV.B.; and (b) residency programs available for physician admission after completion of prerequisite clinical education and training as described in the relevant specialty-specific Program Requirements.

**Review Committee:** A group composed of volunteers that sets accreditation standards (requirements), provides peer evaluation of Sponsoring Institutions or programs to assess the degree to which these comply with the applicable published accreditation requirements, and confers an accreditation status on each Sponsoring Institution or program with regard to substantial compliance with those requirements. There are three types of Review Committee: specialty Review Committee, Transitional Year Review Committee, and Institutional Review Committee.

**Safety event:** An adverse event, near miss, or other event resulting from unsafe conditions in the clinical care setting. May also be referred to as a patient safety event; previously referred to as adverse event in the Common Program Requirements.

**Site visit (accreditation/recognition):** A site visit is conducted by an individual or a team of ACGME-employed Accreditation Field Representative(s) as part of the accreditation and recognition process for Sponsoring Institutions and programs. It addresses compliance with the Institutional and/or relevant Program or Recognition Requirements to inform the Review or Recognition Committee's assessment.

**Self-Study:** An objective, comprehensive evaluation of a Sponsoring Institution or residency/fellowship program, with the aim of improving it. *See the Institutional Requirements and Common Program Requirements for more details*.

**Should:** A term used to designate requirements so important that non-substantial compliance must be justified.

Note: When a "should" requirement is categorized as "Detail," a program holding a status of Continued Accreditation or Continued Recognition, may use alternative or innovative approaches in complying substantially with the associated "Core" requirement(s), where applicable.

**Specialty program:** *See Residency*

**Sponsoring Institution:** The organization (or entity) that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the

ACGME Institutional Requirements.

**Subspecialty program:** *See Fellowship*

**Sub-subspecialty program:** *See Fellowship*

**Summative evaluation:** *See Final Evaluation*

**Transfer resident:** Residents are considered "transfer residents" under several conditions, including: moving from one program to another within the same or between different Sponsoring Institution(s) and within the same or a different specialty; when entering a program requiring a preliminary year at the PGY-2 level even if the resident was simultaneously accepted into the preliminary PGY-1 program and the PGY-2 program as part of the Match (e.g., accepted to both programs right out of medical school).

The term does not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

**Transitional year program:** A one-year educational experience in graduate medical education (GME), which is structured to provide a program of multiple clinical disciplines designed to facilitate the choice of and/or preparation for a specialty. The transitional year is a prerequisite; it does not comprise a complete program in GME.

**Work compression:** An increase in the amount of work to be completed without a corresponding increase in the amount of time provided to complete that work.

# Frequently Asked Questions
## The Milestones

**Quick Contacts**

Email Milestones development and content questions to: Milestones@ACGME.org.

For technical assistance, including questions about specific programs, email ADS@acgme.org and include the program number and question in the body of the email.

Email other specialty-specific questions to the staff of the applicable Review Committee.

| Milestones – General | |
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| What are the Milestones? | For accreditation purposes, the Milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents/fellows from the beginning of their education through graduation to the unsupervised practice of their specialties. |
| What are the Supplemental Guides? | The Supplemental Guides are resources developed in conjunction with a set of Milestones that provide concrete examples, educational information, references, and assessment methods and tools identified to aid in the understanding and use of the Milestones for a given specialty. A Microsoft Word version of each Supplemental Guide is provided with the intent that programs customize the tables with examples, resources, and assessments that are used locally. |
| Can a resident/fellow graduate if Level 4 is not achieved on all milestones? | The ACGME has no required minimums for Milestones reporting. The determination of an individual's readiness for graduation is at the discretion of the program director. |
| Can a resident's/fellow's Milestones reports/assessments be shared with potential fellowship programs with which the individual is interviewing? | Milestones data should not be shared with programs that are interviewing residents/fellows. Once a resident/fellow has matriculated into a new program, the individual's final Milestones evaluation will be available automatically via the ACGME's Accreditation Data System (ADS) to aid in the educational hand-off of the learner and the development of an individualized learning plan. |

| Reporting | |
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| When does reporting take place? | For the most current reporting dates, check the Milestones section of the ACGME website. Typically reporting happens between November and mid-January, and again between April and mid-June each academic year. Note that after the reporting period ends, there is no mechanism to enter the reports. |
| How do combined programs report on the Milestones? | There are varying types of combined programs and Milestones reporting will be different for each.<br><br>If a combined program has a program number (e.g., medical genetics-pediatrics), it will have access to and will report annually on the Milestones for both specialties.<br><br>If a combined program does not have a program number, the Milestones to be reported will be for the specialty in which each resident is enrolled. For example, if a resident completing a rheumatology and pediatric rheumatology program is currently listed in the pediatric rheumatology program complement, the Milestones for Pediatric Rheumatology are those against which the resident should be assessed and which should be reported. However, it is recommended that the Milestones for Rheumatology also be evaluated and shared with the resident. |
| How should a program facilitate evaluation of an off-cycle resident? | Residents/fellows who are "off-cycle" will be reported at the same time as their peers. If a resident/fellow graduates prior to the reporting date, and ADS has been updated prior to the start of the reporting period, there will not be a final report. Programs must ensure that each resident's/fellow's record is updated appropriately, as a report is required for every resident/fellow with an "active" status.<br><br>It is understood that the evaluation of these residents/fellows will differ from those of their peers. If an off-cycle resident/fellow misses a significant portion of the evaluation period, the Clinical Competency Committee (CCC) may choose to hold over the same evaluations as the previous reporting period. If the applicable Review Committee has any concern, it will be able to determine whether an off-cycle resident/fellow is indeed enrolled in the program.<br><br>All residents/fellows, regardless of when they graduate, should receive a final Milestones evaluation.<br><br>If a learner begins on or after September 1 but before or on January 15 – the program will first report that learner's Milestones in the April-June (year-end) reporting period of the current academic year. Note that this includes learners with an "Off-Cycle" status.<br><br>If a learner completes or ends the program on or after September 1 but before or on January 15 – the program will report that learner's final Milestones evaluation in the November-January (mid-year) reporting period of the current academic year. Note that this includes learners with an "Off-Cycle" status. |

| How should a resident/fellow doing a six-month research rotation be evaluated? | Residents and fellows performing research for a duration of six months still need to be evaluated. It is recognized that many of the subcompetencies will not have been evaluated during this period, and as such, the Milestones evaluation would remain as it was during the previous assessment period. |
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| How should a program facilitate the evaluation of a resident/fellow who is rotating through another specialty department? | Residents/fellows who are completing some of their learning in another specialty department (e.g., a categorical neurology resident in internal medicine, an integrated plastic surgery resident in general surgery) must have their Milestones evaluations completed by the program in which they are enrolled. The CCC must use evaluations from the other department to make its Milestones determinations.<br><br>Some of the Medical Knowledge and Patient Care milestones will likely not have been taught/assessed and should be evaluated as such. The other subcompetencies should have been assessed and must be evaluated. The core program should work with the other specialty department to determine the most appropriate assessment method and tool to facilitate good assessment and feedback to both the resident/fellow and the program's CCC. |
| What does the report that the programs can print and place in residents'/fellows' files look like? | After a program submits Milestones data through ADS, a report is prepared (in PDF format) for each individual resident/fellow. The report includes all the milestones the resident achieved during the previous reporting cycle. The program director can choose to print this report and use it as part of the resident's/fellow's semiannual evaluation with the resident/fellow; there is a space for signatures if the program chooses to use it that way. It is not required that programs print these reports; the ACGME does not require any further action after the Milestones data is submitted. |
| When will the "resident report" be available for programs to print? | The individual detailed PDF documents are posted 10-14 days after the close of a reporting window. The reports are then permanently available in ADS. |

| Osteopathic Recognition | |
|---|---|
| Which Milestones are programs with Osteopathic Recognition required to complete? | For each reporting period, programs with Osteopathic Recognition are required to submit resident/fellow assessments on the specialty-specific Milestones, as well as on the Osteopathic Recognition Milestones for those residents/fellows identified in ADS as osteopathic-focused. |
| For programs with Osteopathic Recognition, who is responsible for evaluating residents/fellows against the Osteopathic Recognition Milestones? | Each program with Osteopathic Recognition is required to have at least two osteopathic-focused physician faculty members serving on the CCC for the Osteopathic Recognition Milestones. These physicians may, but are not required to, serve on the specialty-specific CCC as well. |

## Milestones Resources

*Milestones 2.0: Assessment, Implementation, and Clinical Competency Committees Supplement,* new 2021 - https://meridian.allenpress.com/jgme/issue/13/2s

*Clinical Competency Committee Guidebook*, updated 2020 - https://www.acgme.org/Portals/0/ACGMEClinicalCompetencyCommitteeGuidebook.pdf?ver=2020-04-16-121941-380

   *Clinical Competency Committee Guidebook Executive Summaries*, new 2020 - https://www.acgme.org/What-We-Do/Accreditation/Milestones/Resources - Guidebooks - Clinical Competency Committee Guidebook Executive Summaries

*Milestones Guidebook*, updated 2020 - https://www.acgme.org/Portals/0/MilestonesGuidebook.pdf?ver=2020-06-11-100958-330

*Milestones Guidebook for Residents and Fellows*, updated 2020 - https://www.acgme.org/Portals/0/PDFs/Milestones/MilestonesGuidebookforResidentsFellows.pdf?ver=2020-05-08-150234-750

   Milestones for Residents and Fellows PowerPoint, new 2020 - https://www.acgme.org/Residents-and-Fellows/The-ACGME-for-Residents-and-Fellows

   Milestones for Residents and Fellows Flyer, new 2020 - https://www.acgme.org/Portals/0/PDFs/Milestones/ResidentFlyer.pdf

*Implementation Guidebook*, new 2020 - https://www.acgme.org/Portals/0/Milestones%20Implementation%202020.pdf?ver=2020-05-20-152402-013

*Assessment Guidebook*, new 2020 - https://www.acgme.org/Portals/0/PDFs/Milestones/Guidebooks/AssessmentGuidebook.pdf?ver=2020-11-18-155141-527

*Milestones National Report*, updated each fall - https://www.acgme.org/Portals/0/PDFs/Milestones/2019MilestonesNationalReportFinal.pdf?ver=2019-09-30-110837-587 (2019)

*Milestones Bibliography*, updated twice each year - https://www.acgme.org/Portals/0/PDFs/Milestones/MilestonesBibliography.pdf?ver=2020-08-19-153536-447

*Developing Faculty Competencies in Assessment* courses - https://www.acgme.org/Meetings-and-Educational-Activities/Other-Educational-Activities/Courses-and-Workshops/Developing-Faculty-Competencies-in-Assessment

Assessment Tool: Direct Observation of Clinical Care (DOCC) - https://dl.acgme.org/pages/assessment

Assessment Tool: Teamwork Effectiveness Assessment Module (TEAM) - https://dl.acgme.org/pages/assessment

Learn at ACGME, the ACGME's online learning portal, also has several courses on assessment and the Milestones - https://dl.acgme.org/

# ACGME Resident/Fellow Survey – Program FAQs

**What is the Resident/Fellow Survey?**
Each year between January and April, the ACGME requires residents and fellows in accredited programs to complete an online survey. This survey contains questions about the clinical and educational experiences within their program.

**Which programs are scheduled to participate?**
All ACGME-accredited specialty and subspecialty programs with active residents or fellows, regardless of program size, will be surveyed each academic year.

**When are programs scheduled to participate?**
The Resident/Fellow Survey is conducted each academic year between January and April. Programs are scheduled for a single window during which residents/fellows must complete the survey. The ACGME will notify programs of their participation at the beginning of the survey window.

More information about scheduled participation windows for this survey can be found by logging into the Accreditation Data System (ADS). Click on the "Surveys" tab and review the dates under the "Resident/Fellow Survey" heading. *Scheduling for the current academic year usually takes place in late December or early January.*

**Who is scheduled to complete the survey?**
All active residents/fellows within a program will be scheduled to complete the survey each year. Residents/fellows who started the program off-cycle (after August 31 of the current academic year) and who are noted with a current status of "Off-Cycle" in ADS will **NOT** be scheduled to participate.

> *Note: This survey is to be completed only by residents/fellows. Program administrators do not have access to the survey or any individual responses. ADS logins do not grant access to the survey.*

**How will residents/fellows know when to participate?**
It is the responsibility of the program to ensure scheduled residents/fellows complete the survey by the assigned deadline. The ACGME **DOES NOT** notify or remind residents/fellows about this survey.

To notify/remind residents/fellow and provide access to the survey, log into your ADS account, click the "Surveys" tab, and click "View/Remind Takers" under the "Resident/Fellow Survey" heading. Follow the instructions provided to email residents/fellows directly.

**How do residents/fellows complete the survey?**
Residents/fellows can access the survey via a secure link contained in their notification email sent by their program through ADS. Additional information for residents/fellows participating in this survey can be found on the ACGME website.

> *Note: This survey is to be completed only by residents/fellows. Program administrators do not have access to the survey or any individual responses. ADS logins do not grant access to the survey.*

**How can program administrators identify who is scheduled to complete the survey?**
Access a list of scheduled residents/fellows in the program's ADS account. Click on the "Surveys" tab and click "View/Remind Takers" under the "Resident/Fellow Survey" heading. This list will be available ONLY during a program's scheduled survey window for notification/reminder purposes.

**Is there a required response rate programs must meet?**
Yes. A 70-percent response rate is required for all programs with four or more residents/fellows scheduled to participate. Programs with fewer than four residents/fellows scheduled should reach a 100-percent response rate. A survey must be complete and submitted to count towards the program's response rate.

Review Committees will closely monitor the response rates of programs and review those that fail to meet this requirement.

**Can program administrators see the survey questions?**
No. Questions are available to only residents/fellows participating in the survey while they are taking it.

**What types of questions does this survey contain?**
The ACGME Resident/Fellow Survey contains general questions related to the Common Program Requirements and questions regarding well-being. It may also contain questions specific to the specialty/subspecialty or Osteopathic Recognition.

**Which residents/fellows see specialty-specific questions?**
Residents/fellows in the following specialties' may be required to respond to additional specialty-specific questions:

| | | |
|---|---|---|
| Allergy and immunology | Obstetrics and Gynecology | Psychiatry |
| Anesthesiology | Ophthalmology | Radiation oncology |
| Colon and rectal surgery | Orthopaedic surgery (and subs) | Surgery (and subs) |
| Dermatology | Otolaryngology (and subs) | Thoracic surgery |
| Emergency medicine | Pathology | Transitional year |
| Internal medicine (and subs) | Pediatrics (and subs) | Urology |
| Neurological surgery (and subs) | Plastic surgery (and subs) | Combined internal medicine-pediatrics |
| Neurology | Preventive medicine | |

**When is a survey considered "complete"?**
An individual survey is considered complete when all questions presented to the survey taker have been answered and the "Submit" button at the end of the survey has been clicked. Incomplete surveys or surveys that have been saved but not submitted are not considered complete and will NOT count toward a program's overall response rate.

**Is this survey directly linked to a program accreditation site visit?**
No. Residents/fellows are required to complete the survey on an annual basis, regardless of whether the program is scheduled for an accreditation site visit.

**What if a program does not reach a 100-percent response rate for the survey?**
A 70-percent response rate is required for all programs with four or more active residents/fellows. Programs with fewer than four residents/fellows scheduled to participate should reach a 100-percent response rate. Review Committees will closely monitor programs' response rates and may review programs that fail to meet the 70-percent requirement.

**Where can programs review their survey results?**
If at least 70 percent of the program's scheduled residents/fellows complete the survey and there were at least four residents/fellows scheduled to participate, summary reports will be available annually in ADS. Only aggregate summary data are displayed on reports; no individual response data is presented. If a program fails to meet the 70-percent response rate, reports will not be available for the program that academic year.

To download/review survey reports, log into ADS and select the "Survey" option on the "Reports" tab. After choosing an academic year and program, click "View Reports" to access available survey reports for that year.

**Are reports available if a program has fewer than four people scheduled to participate?**
Yes. For programs with fewer than four residents/fellows scheduled to participate in the survey that still meet the required response rate, multi-year reports (containing up to four previous years of survey data) will be made available on an aggregated basis after at least three years of survey data collection have taken place. A program must continue to meet this response rate during this time to receive this report.

Programs that have received a standard report in the past will only receive this multi-year version when there are at least two years of survey data with fewer than four residents/fellows scheduled to participate.

**Who else can see the data from an individual program?**
All data gathered in this survey are confidential. No names will be associated with any of the data collected and no data are linked to individual respondents. Access to reports is password protected, and no individual responses are provided.

Summary data from this survey may be used to inform ACGME policy decisions at the national level. The ACGME may publish summary data and other information about Sponsoring Institutions, programs, resident/fellow physicians, or graduate medical education that is not identifiable by person or organization in a manner appropriate to further the quality of graduate medical education and consistent with federal and state laws and ACGME policies.

**Why are some of the data in the aggregated report highlighted in gray?**
Programs with Resident/Fellow Survey reports prior to and including the 2010-2011 academic year may see gray shaded boxes in the report to highlight non-compliance within responses (as compared to the ACGME Common Program Requirements from that academic year).

# ACGME Faculty Survey – Program FAQs

## What is the Faculty Survey?
Each year between January and April, the ACGME requires faculty members from accredited programs to complete an online survey. This survey contains questions about faculty members' experiences working within their program, as well as about their interactions with the program's residents/fellows.

## Which programs are scheduled to participate?
All ACGME-accredited specialty and subspecialty programs with active residents or fellows, regardless of program size, will be surveyed each academic year.

## When are programs scheduled to participate?
The Faculty Survey is conducted each academic year between January and April. Programs are scheduled for a single window during which faculty members must complete the survey. The ACGME will notify programs of their participation at the beginning of the survey window.

More information about scheduled participation windows for this survey can be found by logging into the Accreditation Data System (ADS). Click on the "Surveys" tab and review the dates under the "Faculty Survey" heading. *Scheduling for the current academic year usually takes place in late December or early January.*

## Who is scheduled to participate in the survey?
Not all faculty members will be scheduled to participate. In subspecialty programs, all faculty members (physician and non-physician) will be scheduled, while in specialty programs only those faculty members indicated as "Core Faculty" on the Faculty Roster will participate (physician and non-physician). The program director will not be surveyed in any program. Confirm that faculty member information is up to date on the "Faculty" tab in ADS.

> *Note: This survey is to be completed only by faculty members. Program administrators do not have access to the survey or any individual responses. ADS logins do not grant access to the survey.*

## How will faculty members know when to participate?
It is the responsibility of the program to ensure scheduled faculty members complete the survey by the assigned deadline. The ACGME **DOES NOT** notify or remind faculty members about this survey.

To notify/remind faculty members and provide access to the survey, log into your ADS account, click the "Surveys" tab, and click "View/Remind Takers" under the "Faculty Survey" heading. Follow the instructions provided to email faculty members directly.

## How do faculty members complete this survey?
Faculty members can access the survey via a secure link contained in their notification email sent by their program through ADS. Additional information for faculty members participating in this survey can be found on the ACGME website.

> *Note: This survey is to be completed only by faculty members. Program administrators do not have access to the survey or any individual responses. ADS logins do not grant access to the survey.*

## How can program administrators identify who is scheduled to complete the survey?
Access a list of scheduled faculty members in the program's ADS account. Click on the "Surveys" tab and click "View/Remind Takers" under the "Faculty Survey" heading. This list will be available ONLY during a program's scheduled survey window for notification/reminder purposes.

### Is there a required response rate programs must meet?
Yes. A 70-percent response rate is required for all programs with four or more faculty members scheduled to participate. Programs with fewer than four faculty members scheduled should reach a 100-percent response rate. A survey must be completed and submitted to count towards the program's response rate.

Review Committees will closely monitor response rates and may review those programs that fail to meet this requirement.

### Can program administrators see the survey questions?
No. Questions are only available to faculty members participating in the survey while they are taking it.

### What types of questions does this survey contain?
The ACGME Faculty Survey contains general questions related to the Common Program Requirements and questions regarding well-being. It does not contain specialty-specific questions.

### Is the survey directly linked to a program accreditation site visit?
No. A program's faculty members are required to complete the survey on an annual basis, regardless of whether the program is scheduled for an accreditation site visit.

### What if a program does not reach a 100-percent response rate for the survey?
A 70-percent response rate is required for all programs with four or more scheduled faculty members. Programs with fewer than four faculty members scheduled to participate in the survey should reach a 100-percent response rate. Review Committees will closely monitor response rates and may review programs that fail to meet the 70-percent requirement.

### Where can programs review their survey results?
If at least 70 percent of the program's scheduled faculty members complete the survey and there were at least four faculty members scheduled to participate, summary reports will be available annually in ADS. Only aggregate summary data are displayed on reports; no individual response data is presented. If a program fails to meet the 70-percent response rate, reports will not be available for the program that academic year.

To download/review survey reports, log into ADS and select the "Survey" option on "Reports" tab. After choosing an academic year and program, click "View Reports" to access available survey reports for that year.

### Are reports available if a program has fewer than four people scheduled to participate?
For programs with fewer than four faculty members scheduled to participate in the survey that still meet the required response rate, multi-year reports (containing up to four previous years of survey data) will be made available on an aggregated basis after at least three years of survey data collection have taken place. A program must continue to meet this response rate during this time to receive this report.

Programs that have received a standard report in the past will only receive this multi-year version when there are at least two years of survey data with fewer than four faculty members scheduled to participate.

### Who else can see the data from an individual program?
All data gathered in this survey are confidential. No names will be associated with any of the data collected and no data are linked to individual respondents. Access to reports is password protected, and no individual responses are provided.

Summary data from this survey may be used to inform ACGME policy decisions at the national level. The ACGME may publish summary data and other information about Sponsoring Institutions, programs, resident/fellow physicians, or graduate medical education that is not identifiable by person or organization in a manner appropriate to further the quality of graduate medical education and consistent with federal and state laws and ACGME policies.

Accreditation Council for
Graduate Medical Education

# Site Visit

> Accreditation and recognition site visits are conducted in person or using remote technology. Sponsoring Institutions and programs will be notified of the modality for their site visit.

**Department of Accreditation, Recognition, and Field Activities**
The accreditation and recognition process for Sponsoring Institutions and programs includes site visits to assess compliance with the applicable Institutional and Program Requirements. All accreditation and recognition site visits for Sponsoring Institutions and programs are performed by Accreditation Field Representatives who are employed by the ACGME.

**About the Accreditation and Recognition Site Visit**

**Question:** **What is the purpose of the accreditation and recognition site visit?**

Answer: The purpose of the accreditation and recognition site visit is collection and aggregation of relevant data. This information is put into a narrative, factual Site Visit Report used by the ACGME Review and Recognition Committees to make accreditation or recognition decisions. Accreditation Field Representatives are not the decision makers; accreditation and recognition decisions are the purview of the Review and Recognition Committees.

**Question:** **Who conducts accreditation and recognition site visits?**

Answer: Accreditation and recognition site visits are conducted by Accreditation Field Representatives, who are professional site visitors employed by the ACGME. Biographical summaries of the Accreditation Field Representatives are available on the ACGME website.

Some site visits to Sponsoring Institutions and programs are conducted by a team of two or more Accreditation Field Representatives. The Site Visit Announcement letter will indicate the name(s) and contact information of the assigned Accreditation Field Representative(s) for the visit.

**Question:** **Why is there more than one Accreditation Field Representative for a remote accreditation or recognition site visit?**

Answer: Accreditation Field Representatives may be assigned alone or with a team member. If included, the second Accreditation Field Representative is available to conduct interviews, manage participants, assist with

technology, and help maintain the security of the remote site visit. Other Accreditation Field Representatives may participate for training purposes.

**Question:** **What are the different types of accreditation and recognition site visits?**

Answer: *Program Applications*
A site visit is conducted to review all specialty and many subspecialty programs when an application for accreditation is submitted. The Accreditation Field Representative will verify and clarify the application documents in which institutional and program leaders have described the resources of the program and how it will comply with the Program Requirements. Applications for Sponsoring Institutions and some subspecialty programs are reviewed without a site visit.

*Sponsoring Institutions and Programs with Initial Accreditation*
All Sponsoring Institutions and programs undergo a site visit at the end of the Initial Accreditation period and prior to a Review Committee's decision to confer the status of Continued Accreditation.

*Continued Accreditation: Annual Data Review Site Visit*
Sponsoring Institutions and programs with a status of Continued Accreditation are subject to an annual screening of accreditation data in ADS. This includes ACGME Resident and Faculty Survey reports; Case Log data (if applicable); surveys about adequacy of patient volume and variety for other specialties; information on scholarly activity for residents/fellows and faculty members; resident/fellow and/or faculty member attrition; and transitions in program and/or institutional leadership. If any of these areas suggests a problem, the Review Committee may ask the program to provide clarifying information or a progress report, or it may schedule a site visit.

*Continued Accreditation: 10-Year Accreditation Site Visits*
All Sponsoring Institutions undergo a site visit following the Self-Study process that includes a description of how the Sponsoring Institution creates an effective learning and working environment, and how this leads to desired educational outcomes.

*Probationary Accreditation*
A Sponsoring Institution or program on Probationary Accreditation will need to have a site visit and be reviewed prior to achieving a status of Continued Accreditation or Continued Accreditation with Warning. These site visits often require a team of Field Representatives.

*Complaint*
After a Review or Recognition Committee considers complaint allegations and the Sponsoring Institution's or program's response to those

complaint allegations, the Review or Recognition Committee may request additional information or a site visit. Such site visits often require a team of Field Representatives.

*Other Site Visits*
Review and Recognition Committees can request site visits at their discretion.

**Question:** **What type of accreditation and recognition site visits are conducted remotely?**

Answer: All types of accreditation and recognition site visits could potentially be conducted remotely, including for both Sponsoring Institutions and programs. Details and decisions on timing and format will be shared as the ACGME considers the impact of the COVID-19 pandemic on the safety and well-being of ACGME staff members and the graduate medical education community.

**Question:** **Can a Sponsoring Institution or program indicate preference for a remote or in-person accreditation site visit?**

Answer: The decision regarding the format of the accreditation and recognition site visit (in-person or remote) is made by the ACGME.

**Question:** **How will a Sponsoring Institution or program know if the site visit will be conducted in person or remotely?**

Answer: Sponsoring Institution and program personnel will be informed about the format of a site visit when they receive the accreditation or recognition site visit blackout date request.

**Question:** **What are accreditation and recognition site visit blackout dates?**

Answer: There is an accreditation and recognition site visit blackout date function for Sponsoring Institutions and programs in ADS, which provides the opportunity to designate dates for the ACGME to avoid when scheduling these visits.

**Question:** **Who can enter blackout dates?**

Answer: Designated institutional officials (DIOs), program directors/directors of osteopathic education, and institutional and program coordinators can enter blackout dates in ADS.

**Question:** **When can blackout dates be entered?**

Answer: In order to select blackout dates in ADS, the Sponsoring Institution or program must first receive an email notice from Field Activities staff

members. After receiving this notice, Sponsoring Institution or program personnel can enter blackout dates and continue to enter or change them until the date a site visit is scheduled.

**Question:** **How many blackout dates can be selected?**

Answer: The number of blackout dates depends on the timeframe of the request. The larger the timeframe, the more blackout dates are offered.

**Question:** **Is entering accreditation/recognition site visit blackout dates required?**

Answer: No. This option is intended to better align Sponsoring Institution and program and site visit scheduling needs.

**Question:** **Are these the same as Clinical Learning Environment Review (CLER) Program blackout dates?**

Answer: No. CLER visit blackout dates are entered separately during designated CLER blackout windows.

**Question:** **Can a Sponsoring Institution or program request to change its site visit date?**

Answer: Due to the logistics involved in conducting a large number of site visits, requests to change a site visit date generally cannot be honored. All Sponsoring Institutions and programs have the opportunity to submit blackout dates before a site visit is scheduled to avoid dates that aren't ideal for the Sponsoring Institution or program.

**Question:** **What electronic equipment/software is needed for a remote accreditation or recognition site visit?**

Answer: Devices (e.g., desktop computer, laptop computer, smartphone, tablet) with audio and visual capability that can run the Zoom application are required. The ACGME recommends all participants for a remote site visit download and set up the free version of the Zoom application. Registration for Zoom or creation of a Zoom account is not required. An alternative technology platform will be used if a Sponsoring Institution or program cannot access Zoom per the institution's' security policy.

**Question:** **What type of internet access is required for remote accreditation and recognition site visits?**

Answer: Participants must have a stable, high-speed internet connection. A laptop or desktop computer with an Ethernet connection is preferred for the DIO/program director and institutional/program coordinator meetings.

**Question:** **What kind of room set-up is best for a remote accreditation or recognition site visit?**

Answer: A quiet environment without interruptions and with good lighting for facial visibility is optimal. Ideally, participants in group sessions would call into the remote interviews individually through their device from a private office or other location. If participants meet as a group in a conference room, the camera needs to show all participants and the microphone should be placed so all participants can be heard by the Accreditation Field Representative(s).

**Preparing for an Accreditation and Recognition Site Visit**

**Question:** **What documents must be submitted into ADS prior to an accreditation or recognition site visit?**

Answer: All site visits require information that is collected via ADS. Instructions on what needs to be updated in ADS prior to the site visit are provided in the Site Visit Announcement letter under the "Updating ADS" section. Sponsoring Institutions and programs should make sure all data in ADS is current prior to the site visit, focusing on responses to citations (if applicable), and changes in the Sponsoring Institutions or program since the last Annual Update.

Review Committee staff members may request additional documents be provided to the (primary) Accreditation Field Representative.

**Question:** **How much notice does Sponsoring Institution or program leadership receive ahead of an accreditation and recognition site visit?**

Answer: The minimum notice for all site visits is approximately 30 days. Notice may be less than 30 days if a site visit is required to meet a Review or Recognition Committee meeting deadline or other circumstances. In these cases, ACGME Field Activities staff members will work with the Sponsoring Institution or program leadership to ensure the site visit is completed.

**Question:** **Who should be present for the site visit?**

Answer: **Program Site Visit (Accreditation)**
Program director, program coordinator(s), DIO and/or Chair (or representative if unavailable), faculty members, residents/fellows (if applicable)

**Institutional Site Visit (Accreditation)**
DIO, institutional coordinator(s), program director(s), program coordinator(s), members of the Graduate Medical Education Committee, other senior institutional officials (e.g., CEO), residents/fellows, faculty members representing all sites

**Program Site Visit (Recognition)**
Program director, Director of Osteopathic Education, designated osteopathic residents/fellows, designated osteopathic faculty members

*Field Representatives may request others depending on the type of site visit or by request of the Review or Recognition Committee

**Question:** **How should residents/fellows be selected to meet with the Accreditation Field Representative(s), and what is expected of them during these interviews?**

**Answer:** The resident/fellow interview is crucial to the accreditation and recognition site visit. For small programs, the Accreditation Field Representative(s) will interview all residents/fellows on duty the day of the visit. For larger programs, residents/fellows that will be interviewed will be peer-selected representing all required years of education.

Those learners beyond the required years of residency (such as fourth-year internal medicine chief residents) or those not in the accredited program may not participate in the resident/fellow interview but may be in the faculty member interview. For programs with a combined program track, such as internal medicine-psychiatry, representative residents from the combined program must be in the interview.

For the site visit of a Sponsoring Institution, the interview group should include residents and fellows representative of the programs sponsored by the institution. For program site visits, residents/fellows often are interviewed in smaller groups, with those in the most senior year(s) of the program interviewed separately. For some types of site visits, residents/fellows may be interviewed individually. The Accreditation Field Representative or team leader who contacts the Sponsoring Institution or program to plan site visit logistics will indicate the interview format. On the day of the site visit, the interview process may change if it appears a different approach will produce better results.

Residents/fellows and faculty members should be available for the entire interview period, with all electronic devices turned off.

**Question:** **What is the Site Visit Attestation Statement?**

**Answer:** All Sponsoring Institutions and programs must upload a signed Site Visit Attestation Statement prior to the site visit. The purposes of the attestation are to: ensure the privacy and confidentiality of the remote interview sessions; affirm that the interview sessions will not be recorded; and state that the Sponsoring Institution or program must not retaliate in any way against any resident/fellow for participation in the site visit or for any statements made by a resident/fellow to the ACGME relating to this site visit.

**During an Accreditation and Recognition Site Visit**

**Question:** **What happens during a program site visit?**

**Answer:** The Accreditation Field Representative(s) conducts interviews with the program director and associate directors (if applicable), residents/fellows, faculty members, the program coordinator, and the DIO and/or other administrative representatives, as well as a review of documents. For some specialties, or if there were prior citations related to facilities, the Accreditation Field Representative(s) may tour selected clinical facilities or request a video tour.

A clarification interview conducted with the program director at the end of the site visit may include feedback from the Accreditation Field Representative, including a succinct summary highlighting two to three key strengths, and suggested improvement in two to three areas. The feedback is based on the Accreditation Field Representative's understanding of the accreditation standards and familiarity with relevant best practices. The Accreditation Field Representative(s) will not offer predictions regarding accreditation outcomes, nor will they assess when the program will be reviewed by the Committee; these decisions are the sole purview of the Review or Recognition Committee.

**Question:** **Does the Accreditation Field Representative(s) meet with the program coordinator, and if so, what information is discussed?**

**Answer:** For most accreditation and recognition site visits, the Accreditation Field Representative(s) will meet briefly with the program coordinator, often in conjunction with the document review portion of the visit.

For some visits, the Accreditation Field Representative(s) may conduct a brief interview with the coordinator to ask about the learning and working environment, institutional support, and professional development for coordinators.

**Question:** **What documents are required for the site visit?**

Answer: The documents required for a site visit review depend on the type of visit. A standard list of each document required by type of visit is attached to the ACGME site visit announcement letter.

Some committees request additional documents for review at the site visit. The assigned Accreditation Field Representative(s) will indicate if such a request has been made for the particular visit.

**Question:** **Will site visit participants be able to privately message the Accreditation Field Representative during a remote accreditation or recognition site visit?**

Answer: Yes. Messages can be sent to the primary Accreditation Field Representative through the Zoom application via the Chat function. Site visit participants will not be able to message each other during an interview.

**Question:** **What should participants do if they experience technical issues with either Zoom or their Internet connection?**

Answer: The Sponsoring Institution's IT department will need to be able to support the technology used during the remote accreditation or recognition site visit. ACGME Audio/Visual staff members will provide support for the ACGME Field Representative(s) who conduct a visit.

**Question:** **In what format should evaluation documents be available during an accreditation and recognition site visit for programs that use electronic resident evaluation systems?**

Answer: Sponsoring Institutions and programs frequently use electronic evaluation systems or data management suites for collection, aggregation, and presentation of a variety of data related to the administration of residency/fellowship programs. The ACGME and its Review and Recognition Committees have clarified expectations regarding information that should be available to the Accreditation Field Representative(s) to enable them to verify the existence of a functioning evaluation process, including discussion of evaluations with residents/fellows. Evidence of this can be offered via traditional paper-based evaluation forms, printouts of electronic evaluations, or the online documents. All formats need to include evidence that these evaluations were reviewed with the resident/fellow, such as the resident's/fellow's signature.

**After the Accreditation and Recognition Site Visit**

**Question:** **What happens after the site visit?**

Answer: After a site visit, the Accreditation Field Representative(s) writes a detailed narrative Site Visit Report that is used, together with information in the ADS, by the Review or Recognition Committee to make its decision. Accreditation Field Representatives do not participate in accreditation or recognition decision making.

All committees meet two or more times each year, and the ACGME strives to review all Sponsoring Institutions and programs in a timely fashion. The schedule of committee meetings and the agenda closing dates for each meeting are listed on the applicable specialty or recognition sections of the ACGME website. DIOs and program directors can contact committee staff members to find out if their Sponsoring Institution or program will be reviewed at a given meeting.

A few days after the meeting during which a Sponsoring Institution or program is reviewed, the committee sends an electronic notice indicating the accreditation or recognition status determined at the meeting. The detailed accreditation or recognition decision will be posted in the institution's or program's ADS account 60 to 90 days after the meeting.

**Question:** **How long does it take to become accredited?**

Answer: The Review Committees and the ACGME give priority to new applications. Programs with applications requiring an accreditation and recognition site visit should expect the process to take as long as four to 12 months. Applications that do not require an accreditation or recognition site visit prior will be reviewed at the next Review or Recognition Committee meeting with room on the agenda (generally within six months of receipt of a completed application).

**Question:** **How can a program ensure the Review Committee reviews the application in a timely fashion?**

Answer: Completing the application with careful attention to detail is the most important initial first step for the program director. The document submitted should demonstrate how the requirements are met in the Sponsoring Institution or program.

Common errors that may delay scheduling of an accreditation and recognition site visit or Committee review include missing or discrepant information about the planned program, missing signatures, or missing

documents, such as Program Letters of Agreement with participating sites. All submissions are considered final.

**Self-Study and 10-Year Accreditation Site Visit**

**Question:** **Will a program's Self-Study be reviewed at the time of the site visit? What happened to the program 10-Year Accreditation Site Visit?**

Answer: The Self-Study will no longer be reviewed during a site visit.

**Question:** **How does a Sponsoring Institution or program know when to initiate its Self-Study?**

Answer: Seven to eight months prior to the Self-Study date noted in ADS, a Sponsoring Institution or program will receive an email from the ACGME to initiate the Self-Study.

Sponsoring Institutions and programs should start their Self-Study at that time but can certainly begin sooner.
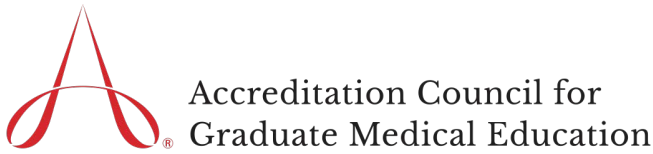
# Self-Study

The ACGME is finalizing its plans for the program Self-Study and developing its process for conducting periodic site visits for programs with a status of Continued Accreditation. The ACGME will not assign program Self-Study dates or 10-Year Accreditation Site Visit dates until further notice. Look for updated information in the coming months. Note: Sponsoring Institution Self-Studies will proceed according to the Institutional Review Committee's announced plan.

**Steps for Conducting The ACGME Program Self-Study**

**The suggested steps described here are intended to offer guidance to programs conducting their Self-Study.**

The Self-Study is an objective, comprehensive evaluation of the residency or fellowship program, with the aim of improving it. Underlying the Self-Study is a longitudinal evaluation of the program and its learning environment, facilitated through sequential annual program evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement ("self-identified" is used to distinguish this dimension of the Self-Study from areas for improvement the Review Committee identifies during accreditation reviews).

To offer context for the Self-Study, there are two concepts: 1) an exploration of program aims; and 2) an assessment of the program's institutional, local and, as applicable, regional environment. Both are discussed in detail below. The focus on aims and the program's environmental context is to enhance the relevance and usefulness of the annual program evaluation, and support improvement that goes beyond compliance with the requirements.

**Assemble the Self-Study Group**

The Self-Study Group Participants: The members of the Program Evaluation Committee (PEC) are the ideal group for the Self-Study, as they are familiar with the Annual Program Evaluation process and the resulting action plans and improvement efforts. Including the program coordinator is also recommended.

Additional Participants: While the ACGME does not require additional participants in the Self-Study process, it may be beneficial to have other individuals offer their perspectives. This might include department leadership, a clerkship director, chief residents (both in the accredited years of training and beyond), or experts in education, curriculum design, or assessment. These individuals should be included if program leaders think that their contributions would be beneficial. The DIO may be able to provide suggestions for institutional experts to include.

CCC Representative: It may be beneficial to include a member of the Clinical Competency Committee (CCC) in the Self-Study group. The CCC possesses educational outcome data, which could provide key input into Self-Study discussions.

**Engage Program Leader and Constituents in a Discussion of Program Aims**

The basic components of the Self-Study is an Annual Program Evaluation. Added components include setting program aims and conducting an abbreviated strategic assessment of the program, focusing on strengths, areas for improvement, opportunities, and threats.

The first task of the Self-Study group is a discussion of program aims. Aims are program and institutional leaders' views of key expectations for the program, as well as how the program differentiates itself from other programs in the same specialty/subspecialty. Aims may focus on the types of residents or fellows recruited by the program, or on preparing graduates for particular careers (clinical practice, academics, research, or primary/generalist care). Aims may also include other objectives, such as care for underserved patients, health policy or advocacy, population health, or generating new knowledge.

Program aims should be vetted with program and institutional leadership, and in some institutions, setting aims will be an institution-level initiative. In setting aims, programs should generally take a longer-term strategic view. However, aims may change over time. Factors such as a shift in program focus initiated by institutional or department leadership, changes in local or national demand for a resident workforce with certain capabilities, or new opportunities to train residents and fellows in a different setting may prompt revision of program aims.

**Aggregate and Analyze Data from Your Annual Program Evaluations and the Self-Study to create a Longitudinal Assessment of Program Strengths and Areas for Improvement**

The central data for the Self-Study is information from successive Annual Program Evaluations, with a focus on program strengths and self-identified areas for improvement; how improvements are prioritized, selected, and implemented; and follow-up to assess whether interventions were effective.

Added data for the Self-Study should relate to ongoing improvement activities and the perspectives of program stakeholders, such as results of the annual ACGME Resident and Faculty Surveys, and relevant departmental or institutional data.

Data aggregation and evaluation should (1) address any active citations and areas for improvement from the program's most recent review; (2) identify any additional areas where the program may not be in compliance with ACGME requirements; and (3) focus on improvement that goes beyond compliance with requirements, with particular attention to improvements relevant to the program's aims.

**Examine the Program's Environment for Opportunities and Threats**

The next step in the Self-Study process is to conduct an assessment of the program's environment. The rationale for examining opportunities for and threats facing the program is to provide context for the Self-Study.

Opportunities: Opportunities are external factors that are not entirely under the control of the program, but if acted on, will help the program flourish. Opportunities take many forms, such as access to expanded populations for ambulatory care at a local health center, partnering with an institution with a simulation center, or availability of new clinical or educational technology through agreements with external parties.

Threats: Threats are also largely beyond the program's control and come in many forms. They could result from a change in support for resident/fellow education at the national level, from changing priorities at the institutional or state level, or from local factors, such as erosion of a primary ambulatory system based on voluntary faculty. The benefit of assessing program threats is that plans can be developed to mitigate their effect.

**Obtain Stakeholder Input on Strengths, Areas for Improvement, Opportunities, and Threats to Prioritize Actions**

These data should be confirmed and augmented by information from program stakeholders (residents/fellows, faculty members, others as relevant). In some cases, important information may include the perceptions of representatives from other specialties who interact with the program's residents or fellows.

To collect this information, the program may use surveys, conduct meetings with residents/fellows, or organize a retreat. Feedback from recent graduates could also provide useful data on the program's educational effectiveness. The only circumstance that may impact accreditation is if the program does not conduct a Self-Study.

Engagement of stakeholders (faculty members, residents, and others, as determined by program leaders) in ongoing conversations about what does and does not work in the program is a critical component of the Self-Study. Stakeholders should also be engaged in a discussion of program aims and an assessment of program context, either as part of the Self-Study or Annual Program Evaluation, or as a stand-alone activity to jumpstart the program's improvement process.

Program leaders, the program coordinator, and others as needed, should assemble a "program improvement" file from prior Annual Program Evaluations and past action plans to use as a starting point for this program improvement effort.

**Interpret the Data and Aggregate the Self-Study Findings**

The next step is to interpret the aggregated data from the Self-Study. Specific elements will include:

a. establish the working set of program aims

b. list key program strengths

c. prioritize among self-identified areas for improvement to select those for active follow-up, and to help define specific improvement activities

d. discuss opportunities that may enhance the program, and developing plans to take advantage of them

e.  discuss threats identified in the Self-Study, and developing plans to mitigate their impact

f.  conduct a five-year look-back using the data from Annual Program Evaluations

g.  conduct a five-year look forward that also seeks to answer the question, "What will take this program to the next level?"

h.  describe any learning that occurred during the Self-Study

**Discuss and Validate the Findings with Stakeholders**

The Self-Study findings from the five-year look forward and the vision for the program should be shared with faculty members and residents/fellows. This step should validate the findings and improvement priorities identified by the Self-Study group with these key stakeholders.

For a specialty program with dependent subspecialty programs, there should be a discussion about any common strengths, areas for improvement, and shared opportunities and threats for some or all of the dependent subspecialties. These may be important priorities for improvements, particularly those requiring institutional resources. Programs should maintain a list of strengths, areas for improvement, and opportunities and threats shared among some or all of the dependent subspecialties.

**Develop a Succinct Self-Study Document for Use in Further Program Improvement**

Programs should maintain a document for their own records that lists the strengths and areas of improvement identified during the Self-Study process in a "program improvement" file.

The next step for the Self-Study group, or an individual designated by the group, is to compile a succinct Self-Study document that describes the process and key findings in the areas of program aims, threats and opportunities assessment, and program strengths and areas for improvement.

Ideally, the role of data collection, aggregation, and tracking of progress for these areas should be assigned to an individual or to a small group (with each individual responsible for a particular area of improvement).

**Approximately One Year after Completion of the Self-Study, Reassemble the Annual Program Evaluation/Self-Study Group to Review the Data in Areas for Improvement Identified in the Self-Study**

The time between completion of the Self-Study with the Annual Program Evaluation and the following year's Annual Program Evaluation will allow programs time to evaluate improvements made in areas the program.

During this evaluation, the program should assess and document progress in areas for improvement identified during the Self-Study.

The Program Evaluation Committee (PEC) or, if desired, the Self-Study group, should review the data collected for areas of improvement identified during the Self-Study.

When the PEC conducts this evaluation prior, a key area to be assessed pertains to the improvements made in areas identified during the Self-Study.

The individual or the team responsible for each improvement area will need to assess progress, as well as identify if improvement has been achieved or if the data constitute early indications of future improvement.

Once the data is reviewed, discuss improvements made as a result of the Self-Study with stakeholders. As part of Annual Program Evaluation, improvements made in areas identified during the Self-Study should be discussed with stakeholders. This may constitute another valuable assessment of the changes made, as faculty members and trainees are in an excellent position to inform program leaders on whether a change has had the desired impact, or if further work is required.

This also allows program leadership to obtain input from stakeholders about the fit between the interventions and improvement initiatives and the program's aims.

**Reassess Program Aims and Other Elements of the Program's Strategic Assessment (Strengths, Areas for Improvement, Opportunities, Threats)**

In most cases, aims will take a longer-term perspective. However, aims may change over time, and it is beneficial to reassess them as part of the Annual Program Evaluation. In addition, the program's context—opportunities and threats—should be reassessed for changes in the environment.

It is important to then discuss program aims, improvements achieved, and other elements of the program's strategic assessment with program stakeholders.

The information on aims and the environmental assessment should be shared and discussed with program leadership and stakeholders. This is another opportunity for faculty members, trainees, the program coordinator, and any other appropriate individuals to have an improvement-focused conversation about the program.

**Complete the Summary of Achievements**

Once the data on program aims and improvements achieved have been discussed and finalized, program leaders should prepare the Summary of Achievements, which is a list of the program's strengths, and improvements made to-date in areas identified during the Self-Study that have not yet resulted in improvements.

For some areas, programs may provide early data on improvements that have not yet been fully realized. See above for a discussion of leading indicators for such longer-term improvements.
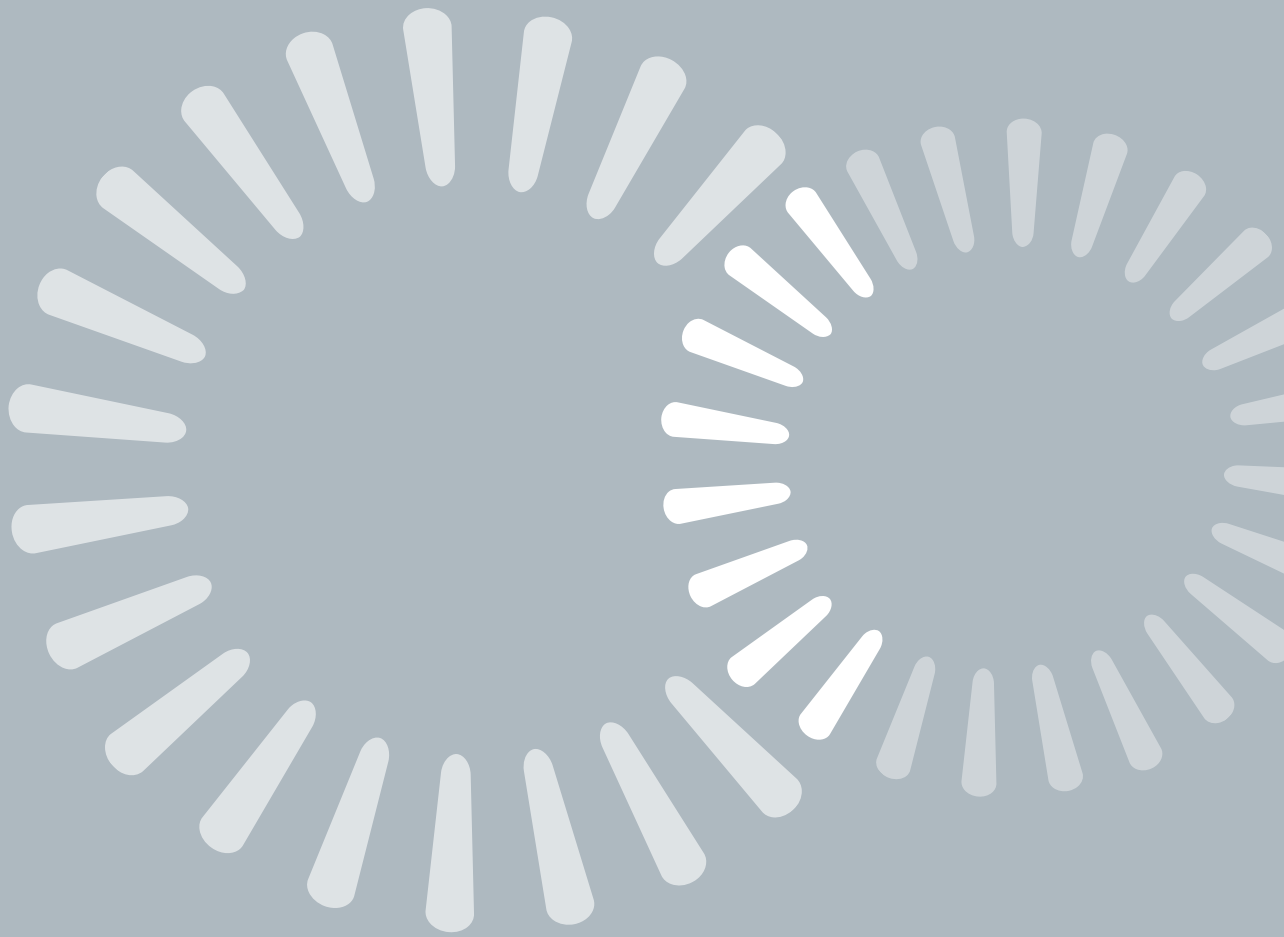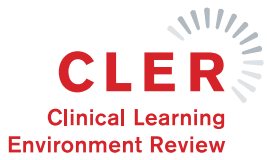
**CLER**

**Clinical Learning
Environment Review**

# CLER PATHWAYS TO EXCELLENCE

## EXPECTATIONS FOR AN OPTIMAL
## CLINICAL LEARNING ENVIRONMENT TO ACHIEVE
## SAFE AND HIGH-QUALITY PATIENT CARE

### VERSION 2.0

**ACGME**

Accreditation Council for
Graduate Medical Education

# CLER Pathways Version 2.0

The Clinical Learning Environment Review (CLER) Program is pleased to present Version 2.0 of *CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment to Achieve Safe and High-Quality Patient Care*. The *Pathways* document continues to serve as a tool for promoting discussions and actions to optimize the clinical learning environment (CLE). This version frames each of the pathways and properties from the health system's perspective, recognizing that health care organizations create and are therefore primarily responsible for the CLE. This focus emphasizes the importance of the interface between graduate medical education (GME) and the hospitals, medical centers, and ambulatory sites that serve as CLEs.

This version of the *Pathways* also places greater emphasis on the clinical care team (and resident and fellow physicians as members of the team). In addition to noting the role of the clinical care team throughout the document, Version 2.0 introduces a new CLER Focus Area called Teaming. The concept of teaming recognizes the dynamic and fluid nature of the many individuals of the clinical care team that come together in the course of providing patient care to achieve a common vision and goals. It also recognizes the benefits of purposeful interactions that allow team members to quickly identify and capitalize on their various professional strengths −coordinating care that is both safe and efficient. This new Focus Area also expressly recognizes and explores the CLE's perspective on the patient's role in teaming. Teaming replaces the previous Focus Area called Care Transitions; the properties from Care Transitions were either retired or redistributed as properties of the other five CLER Focus Areas.

These updates reflect the CLER Program's commitment to continuous improvement toward the goal of optimizing the delivery of safe, high-quality patient care.

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# Introduction

In the late 1990s, the National Academy of Medicine (formerly the Institute of Medicine) conducted a multiyear project to examine the quality of health care in the United States.[1] The result of that effort was a series of reports[2,3] that highlighted serious patient safety concerns, variability in the quality of care, and continuing health care disparities. More than 20 years after the release of those reports, the overall progress in improving the nation's health care has been slow.

The physician workforce is one of the key levers to improving health care. A 2012 survey of hospital leaders conducted by the American Hospital Association found that newly trained physicians were deficient in the areas of communication, use of systems-based practices, and interprofessional teamwork and highlighted the need to educate US physicians, residents, and fellows to address quality improvement.[4]

More than 135,000 resident and fellow physicians train in US teaching hospitals, medical centers, and other clinical settings.[5] These individuals work on the front lines of patient care. In this role, they need to be prepared to recognize patient safety events and intervene when appropriate, to champion performance improvement efforts, and to work effectively in interprofessional[a] teams on systems-based issues such as transitions in patient care. This next generation of physicians needs the skills to be able to lead changes in our nation's health care organizations, both large and small.

The ACGME recognizes the public's need for a physician workforce capable of meeting the requirements of a rapidly evolving health care environment. Efforts to address those needs began in the late 1990s when the ACGME, collaborating with the American Board of Medical Specialties, established six core competencies and designed and implemented a framework for attaining the skills needed for the modern practice of medicine. This framework drives both the educational curriculum and the evaluation of outcomes for residents and fellows. As a subsequent step in the evolution of GME, the ACGME implemented the Next Accreditation System as its current model of accreditation.[6] The Next Accreditation System emphasizes outcomes of resident and fellow learning, assessed through a set of performance measures, including the Milestones, which indicate the individual's progress toward independent practice. Other examples of these measures include: clinical experience as evidenced through the Case Logs, scholarly activity, and pass rates for specialty certification.

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[a] The CLER Program considers "interprofessional" as interactions (e.g., patient care, learning) that involve individuals from two or more clinical professions.

## The CLER Program

The ACGME established the CLER Program in 2012[7] to provide GME leaders and executive leaders of hospitals, medical centers, and other clinical settings with formative feedback aimed at improving patient care while optimizing the CLE in six important cross-cutting areas such as patient safety and health care quality.

The CLER Program conducts site visits to the hospitals, medical centers, and other clinical settings of ACGME-accredited institutions that host residency and fellowship programs.[8] During these visits, CLER Field Representatives meet with the organization's executive leadership (e.g., chief executive officer, chief medical officer, chief nursing officer); the organization's leaders in patient safety, health care quality, and well-being; leaders of GME; and groups of residents and fellows, faculty members, and program directors. Additionally, the CLER site visit teams conduct Walking Rounds on various patient floors, units, and service areas to gather input from other members of the clinical care team regarding how the organization functions as a learning environment.

At the conclusion of each visit, the CLER Field Representatives meet with the organization's executive leadership to share their observations of resident and fellow engagement in the Focus Areas. It is through this feedback that the ACGME seeks to improve both physician education and the quality of patient care within these organizations.

The CLER Program is separate and distinct from nearly all accreditation activities. Two essential elements connect the CLER Program with the rest of the accreditation process: (1) each Sponsoring Institution is required to periodically undergo a CLER site visit every 24 (±6) months; and (2) the chief executive officer and the leader of GME (specifically the designated institutional official) of the clinical site must attend the opening and closing sessions of the CLER site visit.

The CLER Program is built on a model of continuous quality improvement. Its purpose is to evaluate, encourage, and promote improvements in the CLE. The CLER Program provides sites with three types of formative feedback: (1) an oral report at the end of the site visit; (2) a written narrative report summarizing the observations of the CLER Field Representative(s); and (3) reports that provide

national aggregated and de-identified data displayed along a continuum of progress toward achieving optimal resident and fellow engagement in the CLER Focus Areas.

The individual CLER site visit reports are kept confidential. The National Reports of aggregated, de-identified CLER Program data are shared publicly and used to inform future US residency and fellowship accreditation policies, procedures, and requirements.

## Developing the CLER Pathways

The *CLER Pathways to Excellence*[9] document serves a tool to promote discussions and actions to optimize the CLE, furthering the aim of the CLER Program. The ACGME presents the CLER pathways as expectations rather than requirements, anticipating that CLEs will strive to meet or exceed these expectations in their efforts to provide the best care to patients and to produce the highest quality physician workforce.

The ACGME's CLER Evaluation Committee, a group that provides oversight and guidance on all aspects of the CLER Program, develops each version of the *CLER Pathways to Excellence*. The committee's members represent a broad range of perspectives and are selected based on their national and international expertise in areas of patient safety, health care quality, hospital leadership, GME, and patient perspectives. Their continued input, combined with that of the CLER Field Representatives, GME leadership, the executive leadership of Sponsoring Institutions and other clinical sites, and the community—as well as what is learned from the data generated by the CLER site visits—helps to evolve each version of the *CLER Pathways to Excellence* to reflect the current state of GME and the health care system.

## Using the CLER Pathways' Framework

The *CLER Pathways to Excellence* provides a framework for clinical sites to use in their continuing efforts to prepare the clinical care team to deliver consistently safe, high-quality patient care. Central to the document is a series of pathways for each of the six CLER Focus Areas, which are essential to creating an optimal CLE. In turn, each pathway has a series of key properties that can be used to assess resident, fellow, and faculty member engagement within the learning environment.

For example, the Patient Safety Focus Area has seven defined pathways. The first is:

**PS Pathway 1: Education on patient safety**

Five properties are attached to this pathway—each designed to assess the GME connection to the structures and processes the CLE has put in place to promote safe, high-quality patient care. The first is:

*The clinical learning environment:*

*a.  Provides residents, fellows, and faculty members with interprofessional, experiential training on the principles and practices of patient safety.*

In total, Version 2.0 of the *Pathways* document presents six Focus Areas, 34 pathways, and 139 properties. Because the scope and number of pathways and properties are more than can be covered at one time, the CLER Program will not assess all of these elements on every CLER site visit. The CLER Program and the CLER Evaluation Committee hope that CLEs will find valuable guidance in all of the items, regardless of whether they are formally assessed.

Version 2.0 of *Pathways* recognizes the CLE is a shared space, encompassing both early and lifelong learners across the professions. As such, the document focuses on the clinical care team and emphasizes the interdependence of roles and the importance of modeling optimal behaviors for early learners. It also recognizes the key role of patients and caregivers in partnering with the care team to achieve optimal outcomes.

The majority of the pathways and their properties cannot be achieved without a close partnership between the GME leadership and the highest level of executive leadership at the clinical site. The feedback from the CLER Program will assist institutions in prioritizing and acting on opportunities to improve the CLE for resident and fellow physicians and—ultimately—the quality of patient care.

## Informing the Accreditation Process

As noted earlier, the CLER Program provides formative feedback—to individual clinical sites, the ACGME, and the public. The *CLER Pathways to Excellence* document is a tool for assessing the present and simultaneously envisioning and planning for the future. By setting expectations for an optimal CLE, the

pathways and properties serve to stimulate conversations that lead to innovation and improvements in service of both patients and learners. The *CLER Pathways* differ from the ACGME Common Program Requirements and the Institutional Requirements in that they are not utilized to determine the accreditation status of Sponsoring Institutions and their residency programs.

The CLER Program is designed to inform the Common Program Requirements and Institutional Requirements in aggregate. The CLER Evaluation Committee periodically reviews the cumulative data from the CLER site visits, along with emerging research in the six Focus Areas, and uses the information to reassess the pathways, revise them as needed, and make recommendations, as appropriate, regarding potential changes to GME accreditation requirements. As elements of the *CLER Pathways to Excellence* migrate to requirements, these elements are removed from future versions of the document and replaced with new areas for exploration. In this manner, the CLER Program serves as a catalyst to continually inform accreditation, while striving for excellence in patient safety and health care quality.

## Striving for Excellence

The CLER Evaluation Committee and, ultimately, the ACGME Board of Directors continually monitor the progress of the CLER Program. Success associated with the *CLER Pathways to Excellence* is assessed by tracking aggregated data over time and mapping progress along the pathways toward the goal of achieving optimal engagement.

The *CLER Pathways to Excellence* is intended to accelerate national conversations among educators, health care leadership, policy makers, and patients as to the importance of continually assessing and improving the environments in which the US physician workforce trains, as well as the role of GME in promoting safe, high-quality patient care.

# Patient Safety (PS)

The optimal clinical learning environment continually provides experiences that residents and fellows need to engage with the clinical site's efforts to address patient safety. It is important that the clinical site has processes to identify and implement sustainable, systems-based improvements to address patient safety vulnerabilities and that such processes engage interprofessional teams as part of ongoing efforts to deliver the safest and highest quality patient care.[2]

## PS Pathway 1: Education on patient safety

**The clinical learning environment:**

a. Provides residents, fellows, and faculty members with interprofessional, experiential training on the principles and practices of patient safety.

b. Ensures that faculty members are proficient in the application of principles and practices of patient safety.

c. Engages residents and fellows in patient safety educational activities in which the clinical site's systems-based challenges are presented and techniques for designing and implementing system changes are discussed.

d. Provides residents, fellows, and faculty members with education on the clinical site's proactive risk assessments (e.g., failure mode and effects analysis).

e. Ensures that the clinical site's patient safety education program is developed collaboratively by patient safety officers, residents, fellows, faculty members, nurses, and other members of the clinical care team.

## PS Pathway 2: Culture of safety

**The clinical learning environment:**

a. Regularly conducts a culture of safety survey with all members of the clinical care team to identify opportunities for improvement and shares results across the organization.

b. Establishes formal risk-based mechanisms to identify hazards, monitor for potential vulnerabilities, and ensure patient safety.

c. Creates and sustains a fair and just culture for reporting patient safety events for the purposes of systems improvement.

d. Maintains mechanisms to provide second-victim emotional support to the clinical care team involved in patient safety events.

e. Directly reaches out to residents and fellows involved in patient safety events to provide second-victim emotional support.

# Patient Safety CONTINUED

## PS Pathway 3: Reporting of adverse events, near misses/close calls, and unsafe conditions

**The clinical learning environment:**

a. Provides the clinical care team, including residents, fellows, and faculty members, with education on the types of vulnerabilities and range of reportable patient safety events.

b. Ensures that the clinical care team, including residents, fellows, and faculty members, knows the benefits of reporting patient safety events to improve patient care at the clinical site.

c. Ensures that residents, fellows, and faculty members know that it is their responsibility to report patient safety events into the clinical site's central reporting system rather than delegating this responsibility.

d. Captures patient safety events reported by residents, fellows, and faculty members via any mechanism (e.g., online, telephone calls, chain of command) in the clinical site's central reporting system.

e. Provides GME leadership (routinely) and the clinical site's governing body (at least annually) with information on patient safety events reported by residents, fellows, and faculty members.

## PS Pathway 4: Experience in patient safety event investigations and follow-up

**The clinical learning environment:**

a. Ensures that residents and fellows engage in interprofessional, experiential patient safety event investigations that include analysis, implementation of an action plan, and monitoring for continuous improvement related to patient care.

b. Provides direct feedback to members of the clinical care team, including residents and fellows, on the outcomes resulting from personally reporting a patient safety event.

c. Shares lessons learned from patient safety investigations across the organization with all members of the clinical care team, including residents and fellows.

## PS Pathway 5: Clinical site monitoring of resident, fellow, and faculty member engagement in patient safety

**The clinical learning environment:**

a.  Monitors resident, fellow, and faculty member reporting of patient safety events.

b.  Monitors resident, fellow, and faculty member participation in patient safety event investigations.

c.  Uses data from monitoring resident, fellow, and faculty member patient safety reports to develop and implement actions that improve patient care.

d.  Monitors resident, fellow, and faculty member participation in implementing action plans resulting from patient safety event investigations.

## PS Pathway 6: Resident and fellow education and experience in disclosure of events

**The clinical learning environment:**

a.  Provides residents and fellows with experiential training with their faculty members (e.g., simulated or authentic patient care experience) in the clinical site's process for disclosing patient safety events to patients and families.

b.  Ensures that residents and fellows are involved with faculty members in disclosing patient safety events to patients and families at the clinical site.

## PS Pathway 7: Resident, fellow, and faculty member engagement in care transitions

**The clinical learning environment:**

a.  Provides residents, fellows, and faculty members with simulated or real-time interprofessional training on communication to optimize transitions of care at the clinical site.

b.  Ensures that residents, fellows, and faculty members use a common clinical site-based process for change-of-duty hand-offs.

c.  Ensures that residents, fellows, and faculty members use a standardized direct verbal communication process for patient transfers between services and locations at the clinical site.

d.  Involves residents, fellows, and program directors in the development and implementation of strategies to improve transitions of care.

e.  Monitors transitions of patient care managed by residents and fellows.

# Health Care Quality (HQ)

The optimal clinical learning environment provides experiential and interprofessional training in all phases of quality improvement aligned with the quality goals of the clinical site.[3] In this way, it ensures that residents and fellows engage with the entire cycle of quality improvement—from planning through implementation and reassessment.

## HQ Pathway 1: Education on quality improvement

**The clinical learning environment:**

a. Ensures that residents, fellows, and faculty members are familiar with the clinical site's priorities and goals for quality improvement.

b. Provides the clinical care team, including residents, fellows, and faculty members with ongoing education and training on quality improvement that involves experiential learning and interprofessional teams.

c. Engages residents, fellows, and faculty members in quality improvement educational activities where the clinical site's systems-based challenges are presented, and techniques for designing and implementing systems changes are demonstrated.

d. Ensures that the clinical site's quality improvement education program is developed collaboratively by quality officers, residents, fellows, faculty members, nurses, and other members of the clinical care team to reflect the clinical site's quality program's priorities and goals.

e. Ensures the integration of quality improvement processes and lessons learned into the daily workflow of clinical care.

## HQ Pathway 2: Resident and fellow engagement in quality improvement activities

**The clinical learning environment:**

a. Provides opportunities for residents and fellows to actively engage in interprofessional quality improvement.

b. Ensures that residents and fellows actively engage in interprofessional quality improvement that is aligned and integrated with the clinical site's priorities for sustained improvements in patient care.

c. Maintains a central repository for all quality improvement projects, including resident- and fellow-led projects, to monitor progress and assess the quality of the projects.

d. Shares quality improvement outcomes with all members of the clinical care team, including residents and fellows, across the organization.

## HQ Pathway 3: Data on quality metrics

**The clinical learning environment:**

a. Provides the clinical care team, including residents and fellows, with clinical site-level quality metrics and benchmarks.

b. Provides the clinical care team, including residents and fellows, with aggregated data on quality metrics and benchmarks related to their patient populations.

c. Provides the clinical care team, including residents and fellows, with data on quality metrics and benchmarks specific to the patients for whom they provide direct patient care.

d. Ensures that the clinical care team, including residents, fellows, and faculty members, can interpret data on quality metrics and benchmarks.

## HQ Pathway 4: Resident and fellow engagement in the clinical site's quality improvement planning process

**The clinical learning environment:**

a. Engages residents, fellows, and faculty members in strategic planning for quality improvement.

b. Engages residents, fellows, and faculty members in interprofessional service-line, departmental, and clinical site-wide quality improvement committees.

c. Periodically reviews resident and fellow quality improvement projects to integrate with the clinical site's quality improvement planning process.

## HQ Pathway 5: Resident, fellow, and faculty member education on eliminating health care disparities

**The clinical learning environment:**

a. Provides the clinical care team, including residents, fellows, and faculty members with education on the differences between health disparities and health care disparities.

b. Ensures that residents, fellows, and faculty members know the clinical site's priorities for addressing health care disparities.

c. Educates residents, fellows, and faculty members on identifying and eliminating health care disparities among specific patient populations receiving care at the clinical site.

d. Maintains a process that informs residents, fellows, and faculty members on the clinical site's process for identifying and eliminating health care disparities.

# Health Care Quality CONTINUED

## HQ Pathway 6: Resident, fellow, and faculty member engagement in clinical site initiatives to eliminate health care disparities

**The clinical learning environment:**

a. Engages residents, fellows, and faculty members in defining strategies and priorities to eliminate health care disparities among its patient population.

b. Identifies and shares information with residents, fellows, and faculty members on the social determinants of health for its patient population.

c. Provides residents, fellows, and faculty members with quality metrics data on health care disparities grouped by its patient population.

d. Provides opportunities for residents, fellows, and faculty members to engage in interprofessional quality improvement projects focused on eliminating health care disparities among its patient population.

e. Monitors the outcomes of quality improvement initiatives aimed at eliminating health care disparities among its patient population.

## HQ Pathway 7: Residents, fellows, and faculty members deliver care that demonstrates cultural humility

**The clinical learning environment:**

a. Provides residents, fellows, and faculty members continual training in cultural humility relevant to the patient population served by the clinical site.

b. Ensures that the clinical care team, including residents, fellows, and faculty members, delivers care that incorporates the views of culturally diverse patient populations.

# Teaming (T)

The optimal clinical learning environment supports high-performance teaming. The concept of teaming recognizes the dynamic and fluid nature of the many individuals of the clinical care team that come together in the course of providing patient care to achieve a common vision and goals.[10] Teaming recognizes the benefits of purposeful interactions in which team members quickly identify and capitalize on their various professional strengths–coordinating care that is both safe and efficient. The team members collaborate and share accountability to achieve outstanding results.

## T Pathway 1: Clinical learning environment promotes teaming as an essential part of interprofessional learning and development

**The clinical learning environment:**

a. Maintains an organizational strategy to promote interprofessional learning on teaming.

b. Provides continual interprofessional educational programming on teaming that engages residents, fellows, and faculty members.

c. Ensures the development and maintenance of interprofessional skills on teaming that engages residents, fellows, and faculty members.

d. Ensures continual interprofessional learning on teaming that engages residents, fellows, and faculty members across the continuum of patient care and at all care delivery sites.

e. Engages in continual goal-setting and monitoring of interprofessional learning on teaming.

## T Pathway 2: Clinical learning environment demonstrates high-performance teaming

**The clinical learning environment:**

a. Ensures that patient care planning by residents, fellows, and faculty members (e.g., diagnostic and treatment strategies) is conducted in the context of interprofessional teams.

b. Ensures that transitions in care conducted by residents, fellows, and faculty members (e.g., change-of-duty hand-offs, transfers of patients between services and locations) involves, as appropriate, interprofessional teams.

c. Engages residents, fellows, and faculty members in interprofessional performance improvement activities, including patient safety and quality improvement, across service lines and health care settings.

d. Ensures that patient care processes are designed with interprofessional collaborative input, including the GME community.

# Teaming CONTINUED

## T Pathway 3: Clinical learning environment engages patients* to achieve high-performance teaming

**The clinical learning environment:**

a. Maintains a strategy to engage patients as part of its effort to ensure high-performance teaming.

b. Ensures that patients are engaged with their clinical care team in decisions related to their care.

c. Engages patients in the development and revision of the clinical site's policies and procedures on patient care in which residents and fellows are involved (e.g., duty hours, supervision, informed consent).

d. Ensures that patients are involved, as appropriate, in resident and fellow care transitions (e.g., change-of-duty hand-offs).

## T Pathway 4: Clinical learning environment maintains the necessary system supports to ensure high-performance teaming

**The clinical learning environment:**

a. Provides professional development resources to ensure interprofessional learning and high-performance teaming that includes residents, fellows, and faculty members.

b. Provides interprofessional resources to support teaming activities within and across service lines and health care settings.

c. Monitors the use of interprofessional resources to support high-performance teaming.

d. Ensures that information technology personnel are integrated into interprofessional teams and that resources are available to support high-performance teaming.

e. Demonstrates how it engages the clinical care team, including residents, fellows, and faculty members, in integrating artificial intelligence (e.g., decision support) to support high-performance teaming.

f. Monitors the degree of patient engagement in the design and practice of teaming.

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\* "Patient" can include family members, caregivers, patient legal representatives, and others.

# Supervision (S)

The optimal clinical learning environment provides all members of the clinical care team and patients with mechanisms to raise supervision concerns. It also continuously monitors resident and fellow supervision to implement actions that enhance patient safety.[11] For each resident and fellow, GME encompasses progressive levels of supervision throughout the educational program.

## S Pathway 1: Education on supervision

**The clinical learning environment:**

a. Educates the clinical care team, including residents, fellows, and faculty members, on GME expectations for supervision and progressive autonomy throughout the residency and fellowship experience.

b. Educates residents, fellows, and faculty members on the clinical site's expectations on how GME provides effective supervision of patient care.

## S Pathway 2: Culture of supervision

**The clinical learning environment:**

a. Ensures that residents and fellows receive adequate supervision as defined by the clinical site.

b. Maintains a culture of supervision such that residents and fellows feel safe and supported in requesting assistance in the delivery of patient care.

c. Fosters a supportive and nonpunitive culture of supervision for members of the clinical care team to report concerns about resident and fellow supervision.

d. Ensures that mechanisms are in place for the clinical care team, including residents and fellows, to escalate supervision concerns in real-time.

e. Establishes expectations for and monitors the quality of supervision of consultative services provided by residents and fellows.

# Supervision CONTINUED

## S Pathway 3: Roles of clinical staff members other than physicians in resident and fellow supervision

**The clinical learning environment:**

a. Ensures that clinical staff members other than physicians act on concerns related to the supervision of residents and fellows.

b. Ensures that clinical staff members other than physicians are knowledgeable about the clinical site's expectations for supervision and progressive autonomy throughout the residency and fellowship experience.

c. Periodically assesses the perceptions of clinical staff members other than physicians that the clinical site provides residents and fellows with a supportive culture for requesting assistance from supervising physicians.

d. Ensures that clinical staff members other than physicians escalate concerns when supervision policies and procedures are not followed at the clinical site.

## S Pathway 4: Patient* perspectives on graduate medical education supervision

**The clinical learning environment:**

a. Ensures that patients understand the roles and are able to identify the names of attending physicians, residents, and fellows caring for them at the clinical site.

b. Ensures that patients have adequate contact with the resident and fellow team caring for them at the clinical site.

c. Communicates to patients the mechanism for them to directly contact the attending physician in charge of their care about concerns with supervision.

d. Includes patients' perceptions in monitoring adequate supervision of residents and fellows.

* "Patient" can include family members, caregivers, patient legal representatives, and others.

## S Pathway 5: Clinical site monitoring of resident and fellow supervision and workload

**The clinical learning environment:**

a. Maintains information systems, accessible by the clinical care team, to verify the level of supervision required for residents and fellows to perform specific patient procedures.

b. Monitors the use of systems to verify the level of supervision required for residents and fellows to perform specific patient procedures.

c. Ensures that mechanisms are in place to systematically monitor and expeditiously address potential patient care vulnerabilities due to resident and fellow supervision.

d. Monitors for patient care vulnerabilities due to the impact of faculty workload on resident and fellow supervision to formulate and implement strategies to mitigate the vulnerabilities.

e. Monitors and assesses faculty member supervision of resident and fellow transfers of patient care, including change-of-duty and between services and locations at the clinical site.

# Well-being (WB) – SELECTED TOPICS

The optimal clinical learning environment is engaged in systematic and institutional strategies and processes to cultivate and sustain the well-being of both its patients and its clinical care team.[12] The delivery of safe and high-quality patient care on a consistent and sustainable basis can be rendered only when the clinical learning environment ensures the well-being of clinical care providers.
The following pathways and properties reflect selected topics in this area.

## WB Pathway 1: Clinical learning environment promotes well-being across the clinical care team to ensure safe and high-quality patient care

a. The clinical site creates a supportive clinical care community that is free of stigma, that is safe, and that embraces, promotes, and supports well-being.

b. Leadership engages front-line health care providers in designing and developing priorities and strategies that support well-being.

c. The clinical site builds awareness and educates the clinical care team on the risks, signs, symptoms, and recognition of fatigue in the context of patient care specific to the clinical site.

d. The clinical site builds awareness and educates the clinical care team on the risks, signs, symptoms, and recognition of burnout in the context of patient care specific to the clinical site.

e. Clinical learning environment and GME leadership demonstrate behaviors that promote well-being, thereby serving as role models for the clinical care team.

## WB Pathway 2: Clinical learning environment demonstrates specific efforts to promote the well-being of residents, fellows, and faculty members

a. Leadership engages residents, fellows, and faculty members in designing, developing, and continually stewarding priorities and strategies that support well-being.

b. The clinical learning environment demonstrates continuous effort to support programs and activities that enhance the physical and emotional well-being of residents, fellows, and faculty members.

## WB Pathway 3: Clinical learning environment promotes an environment where residents, fellows, and faculty members can maintain their personal well-being while fulfilling their professional obligations

**The clinical learning environment:**

a. Establishes organizational expectations for resident, fellow, and faculty member workload—duration and intensity—consistent with safe and high-quality care for their patients and the educational needs of GME.

b. Identifies and monitors patient care activities by residents, fellows, and faculty members that exceed the expectations of duration and intensity (volume and complexity) set by the clinical learning environment.

c. Demonstrates continued improvement efforts to eliminate work-related activities that exceed the expectations of duration and intensity (volume and complexity) set by the clinical learning environment.

d. Seeks and implements longitudinal approaches to enhance residents, fellows, and faculty members' ability to balance their personal needs with that of their work-related responsibilities.

## WB Pathway 4: Clinical learning environment demonstrates system-based actions for preventing, eliminating, or mitigating impediments to the well-being of residents, fellows, and faculty members

**The clinical learning environment:**

a. Promotes resilience training that is interprofessional and includes residents, fellows, and faculty members to ensure the safe and effective care of their patients.

b. Ensures that systems are in place to actively recognize and mitigate fatigue among residents, fellows, and faculty members.

c. Ensures that systems are in place to actively recognize and alleviate burnout among residents, fellows, and faculty members.

d. Identifies GME-related systems and processes that may impede well-being in the clinical learning environment and works with the Sponsoring Institution to eliminate these impediments.

e. Identifies clinical site-related systems and processes that may impede well-being in the clinical learning environment and works to eliminate these impediments.

# Well-being CONTINUED

## WB Pathway 5: Clinical learning environment demonstrates mechanisms for identification, early intervention, and ongoing support of residents, fellows, and faculty members who are at risk of or demonstrating self-harm

**The clinical learning environment:**

a.  Builds awareness and educates the clinical care team on the risks, signs, symptoms, and recognition of those who are at risk of or demonstrating self-harm.

b.  Ensures confidentiality and actively facilitates early detection of residents, fellows, and faculty members at risk of or demonstrating self-harm.

c.  Establishes systems or processes that provide residents, fellows, and faculty members at risk of or demonstrating self-harm confidential access to treatment and other related services that are commensurate with occupational and personal needs.

d.  Effectively addresses the emotional needs of its residents, fellows, and faculty members in relation to catastrophic work-related events (in the course of patient care or among the members of the clinical care team).

## WB Pathway 6: Clinical learning environment monitors its effectiveness at achieving the well-being of the clinical care team

**The clinical learning environment:**

a.  Actively monitors and assesses the effectiveness of its efforts to promote the optimal integration of work with personal needs related to self, family, friends, and community.

b.  Actively monitors and assesses the effectiveness of its efforts to eliminate harm to patients due to clinician fatigue.

c.  Actively monitors and assesses the effectiveness of its efforts to eliminate harm to patients due to clinician burnout.

d.  Actively monitors and assesses the effectiveness of its efforts to assess and provide care for those who are at risk of or demonstrating self-harm.

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# Professionalism (PR) – SELECTED TOPICS

The optimal clinical learning environment recognizes that attitudes, beliefs, and skills related to professionalism directly impact the quality and safety of patient care. It has mechanisms in place for reporting concerns around professionalism, periodic assessment of concerns and identification of potential vulnerabilities, and the provision of feedback and education related to resulting actions.[13] The following pathways and properties reflect selected topics in this area.

## PR Pathway 1: Education on professionalism

**The clinical learning environment:**

a.  Educates the clinical care team, including residents, fellows, and faculty members, on the clinical site's expectations for professional conduct in an interprofessional environment.

b.  Educates the clinical care team, including residents, fellows, and faculty members, on clinical site, regional, and national issues of professionalism (e.g., appropriate use of copyrighted material, documentation practices).

## PR Pathway 2: Culture of professionalism

**The clinical learning environment:**

a.  Promotes a culture of professionalism that supports honesty, integrity, and respectful treatment of others.

b.  Ensures that residents and fellows follow the clinical site's policies, procedures, and professional guidelines when documenting (e.g., work hours, moonlighting, Case Log reporting).

c.  Ensures that residents, fellows, and faculty members follow the clinical site's policies, procedures, and professional guidelines when documenting in the electronic medical record—with special attention to documentation of clinical information that is based on direct assessment or appropriately attributed information.

d.  Ensures a culture of professionalism in which residents and fellows immediately report any unsafe conditions in patient care, drawing the clinical care team's attention to unsafe events in progress (e.g., "stop the line").

e.  Provides mechanisms for members of the clinical care team, including residents, fellows, and faculty members, to report concerns about professionalism without retaliation.

f.  Ensures that residents, fellows, and faculty members engage in timely, direct, and respectful communication in the development of patient care plans among primary and consulting teams.

# Professionalism CONTINUED

## PR Pathway 3: Conflicts of interest

**The clinical learning environment:**

a. Educates residents and fellows on its conflict of interest policies and potential issues related to patient care, including the clinical site's conflicts of interest.

b. Educates residents and fellows on how the clinical site supports residents and fellows in managing conflicts of interests that they encounter.

c. Ensures that residents, fellows, and faculty members disclose potential conflicts of interest throughout resident and fellow education and patient care.

d. Maintains databases on resident, fellow, and faculty member potential conflicts of interest (e.g., research funding, commercial interests) that are accessible to the clinical care team.

e. Assesses patient safety events for issues related to resident, fellow, and faculty member conflicts of interest.

## PR Pathway 4: Patient* perceptions of professional care

**The clinical learning environment:**

a. Educates residents, fellows, and faculty members on how patient experience data on professionalism are used to improve patient care.

b. Routinely provides residents, fellows, and faculty members with patient experience data on professionalism at the clinical site.

## PR Pathway 5: Clinical site monitoring of professionalism

**The clinical learning environment:**

a. Routinely assesses the culture of professionalism and uses that information to continuously improve the clinical site.

b. Monitors documentation practices related to resident, fellow, and faculty member use of the electronic medical record and other sources of patient health information.

c. Monitors for the appropriate use of copyrighted material available to the public as part of education efforts around in-service and board examinations.

d. Monitors for accurate reporting of resident and fellow work hours.

e. Effectively addresses reported behaviors of unprofessionalism and ensures that the clinical site is absent of chronic, persistent unprofessional behavior.

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* "Patient" can include family members, caregivers, patient legal representatives, and others.

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# ECFMG® CERTIFICATION
# 2023 INFORMATION BOOKLET

## Stay Up to Date

- Monitor the ECFMG website at www.ecfmg.org for any changes to the information in this booklet.

- Subscribe to *The ECFMG Reporter* e-newsletter.

- Follow us on social media.

Intealth brings together the expertise of ECFMG and FAIMER® to advance quality in health care education worldwide in order to improve health care for all.

September 14, 2022

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# Introduction

## About the ECFMG Information Booklet and Application Materials

The ECFMG *Information Booklet* contains detailed information on ECFMG's program of certification. The information contained in this booklet pertains only to the ECFMG certification process and related applications and services.

Applicants for examination must use the applicable edition of the *Information Booklet*. The 2023 *Information Booklet* pertains to eligibility periods in 2023. If your eligibility period extends into 2024 and you test in 2024, you must become familiar with and will be subject to the policies and procedures detailed in the 2024 *Information Booklet*. The 2024 *Information Booklet* is expected to be available in September 2023. See the information on eligibility periods under *Applying for Examination* in *The United States Medical Licensing Examination (USMLE)* section of this booklet.

The USMLE *Bulletin of Information* provides information about the USMLE, a three-step examination for medical licensure in the United States. In the event that information about the USMLE in the ECFMG *Information Booklet* differs from the corresponding information in the USMLE *Bulletin of Information*, the information in the USMLE *Bulletin of Information* controls.

## Required Reading

**Applicants for examination are required to read and become familiar with the information contained in and referenced in both the ECFMG** *Information Booklet* **and the USMLE** *Bulletin of Information*. The USMLE *Bulletin of Information* is available on the USMLE website [↗]. Applicants also must carefully review and be familiar with the detailed instructions for the USMLE application and the *Policies and Procedures Regarding Irregular Behavior*.

## Staying Up-to-Date

Although current at the time of publication, the information contained in the 2023 *Information Booklet* is subject to change. If changes occur, information will be posted on the ECFMG website. **You are responsible for checking the ECFMG website for updates and changes.**

ECFMG provides important updates on ECFMG Certification and entry into graduate medical education in the United States in its newsletter, *The ECFMG® Reporter*, and via Facebook and Twitter. ECFMG encourages applicants to subscribe to *The ECFMG® Reporter* and to follow ECFMG on Facebook [↗] and Twitter [↗].

## Deadlines – Eastern Time

The *Information Booklet* describes deadlines related to exam applications, scheduling, and other services. Unless otherwise indicated, deadlines are calculated using Eastern Time in the United States.

## Privacy

Consistent with Intealth's Privacy Notice, ECFMG may share the information contained in your application, or that otherwise may become available to ECFMG, with any federal, state or local governmental department or agency, with any hospital, training program or any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information. This may include reporting determinations of irregular behavior to the USMLE Committee for Individualized Review, Federation of State Medical Boards of the United States, U.S. state and international medical licensing authorities, graduate medical education programs, and to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information. For further information regarding our data collection and privacy practices, please refer to our Privacy Notice.

## Information and Documents You Provide to Us

The information you provide to us as part of any application or service request will become a part of your permanent record, including the information you provide as part of the process of obtaining a USMLE/ECFMG Identification Number or other identification number. All correspondence with us, including e-mails, also will become a part of your permanent record.

All documents that you submit to us as part of the certification process, including supporting documentation, translations, etc., will become part of your permanent record and will not be returned to you. Do not send original documents.

## Application/Service Request Processing

ECFMG strives to ensure proper processing of applications for ECFMG Certification and examination, related service requests, and the information contained in such applications and requests. In the unlikely event that an error occurs in the processing of applications, requests, or associated materials, ECFMG will make reasonable efforts to correct the error, if possible, or permit you either to reapply at no additional fee or to receive a refund. These are the exclusive remedies available to applicants for errors in processing applications and other service requests related to ECFMG Certification, examination, and the other services described in this booklet.

Please note that ECFMG will not provide services of any kind if doing so would be considered violative of any applicable international, federal, state, or local laws or regulations. Additionally, ECFMG may delay or suspend provision of services while investigating whether the services or surrounding circumstances violate such laws, regulations, or ECFMG's policies and procedures.

# Introduction

## Important Notices

This *Information Booklet* reflects information available and requirements in place at the time of publication (September 14, 2022). International medical graduates pursuing ECFMG Certification should monitor the ECFMG and USMLE websites for the most current information.

## Our New Identity

In 2021, ECFMG and its Foundation for Advancement of International Medical Education and Research (FAIMER®) announced a new, overarching identity, Intealth. This new identity reflects an integrated approach to our operations and our enhanced ability to support the health professions worldwide. As a member of Intealth, ECFMG continues to administer its portfolio of programs and services, including its program of ECFMG Certification, and to support international medical graduates who seek entry to graduate medical education in the United States. To learn more, please visit Intealth on the ECFMG website.



## Launch of MyIntealth in 2023

In 2023, we plan to launch MyIntealth, a new on-line portal that will provide access to ECFMG services. Applicants for ECFMG Certification will establish a MyIntealth account and will have one applicant record for all services. MyIntealth will replace most of ECFMG's current on-line services and forms for applicants pursuing ECFMG Certification and U.S. graduate medical education. The launch of MyIntealth will result in changes to policies and procedures described in this booklet. Please monitor ECFMG's website for updates.

## Requirements for ECFMG Certification for the Match

To be eligible to participate in the National Resident Matching Program (the Match), international medical graduates must have satisfied the examination requirements for ECFMG Certification by the NRMP's Rank Order List Certification deadline. See *Examinations for ECFMG Certification* for more information.

## Introduction

### Guide to On-line Services and Forms

**Important Note:** In 2023, we plan to launch MyIntealth, a new on-line portal that will provide access to ECFMG services. Applicants for ECFMG Certification will establish a MyIntealth account and will have one applicant record for all services. MyIntealth will replace most of ECFMG's current on-line services and forms for applicants pursuing ECFMG Certification and U.S. graduate medical education. The launch of MyIntealth will result in changes to policies and procedures described in this booklet. Please monitor ECFMG's website for updates.

ECFMG's on-line services and forms for applicants pursuing ECFMG Certification are available on the ECFMG website.

### Use Interactive Web Applications (IWA) to:

- Obtain a USMLE/ECFMG Identification Number
- Complete the Application for ECFMG Certification, including the notarized *Certification of Identification Form* (Form 186)
- Apply for USMLE
- Access your *Certification Statement* (Form 183) if your medical school prefers to verify student/graduate status via paper form
- Read about *ECFMG's Provision of Performance Data to Medical Schools* and request to withhold your exam results from your medical school
- Access your USMLE scheduling permit (when available)
- Request to extend a USMLE Step 1/Step 2 CK eligibility period

### Use ECFMG Credentials Upload Tool to:

- Submit your final medical diploma and other related documents to meet the medical education credentials requirements

### Use Application for Pathways for ECFMG Certification for Match to:

- Apply to a Pathway to meet the clinical skills and communication skills requirements for ECFMG Certification

### Use On-line Applicant Status and Information System (OASIS) to:

- Check and update your contact information
- Check the status of your medical education credentials
- Check and make a payment to your financial account
- Access your USMLE score report (when available)
- Confirm whether you have submitted an Application for ECFMG Certification and have a valid *Certification of Identification Form* (Form 186) on file

## Use Forms to:

- Change the name or date of birth in your record
- Change your USMLE Step 1 or Step 2 CK testing region
- Request an official USMLE transcript
- Request an official ECFMG CSA History Chart
- Request a Step 1 or Step 2 CK score recheck
- Make a payment to your financial account

## Use E-Newsletters to:

- Subscribe/unsubscribe from e-newsletters
- Change the e-mail address you use to subscribe to e-newsletters

## Use mail/courier service:

- If you are unable to use the ECFMG Credentials Upload Tool to submit your final medical diploma and other related documents to ECFMG, you may submit paper copies.

Mailing Address:
Educational Commission for Foreign Medical Graduates (ECFMG)
Attn: Certification Credentials Services
3624 Market St., 4th Floor Philadelphia, PA 19104-2685 USA

ECFMG will not accept letters or other deliveries that arrive with postage or other fees due.

Do not send original documents. The photocopy of your credential or related document must be 216 mm x 279 mm (8½ in x 11 in). If the document is larger than 216 mm x 279 mm (8½ in x 11 in), you must send a reduced photocopy that is 216 mm x 279 mm (8½ in x 11 in).

## ECFMG Certification

### About ECFMG Certification

The Educational Commission for Foreign Medical Graduates (ECFMG), through its program of certification, assesses whether international medical graduates are ready to enter residency or fellowship programs in the United States that are accredited by the Accreditation Council for Graduate Medical Education (ACGME) ⬈. ACGME requires international medical graduates who enter ACGME-accredited programs to be certified by ECFMG.

ECFMG Certification assures directors of ACGME-accredited residency and fellowship programs, and the people of the United States, that international medical graduates have met minimum standards of eligibility to enter such programs. ECFMG Certification does not, however, guarantee that these graduates will be accepted into programs; the number of applicants each year exceeds the number of available positions.

ECFMG Certification is also one of the eligibility requirements for international medical graduates to take Step 3 of the three-step USMLE ⬈. Medical licensing authorities in the United States require that international medical graduates be certified by ECFMG, among other requirements, to obtain an unrestricted license to practice medicine.

ECFMG defines an international medical graduate as a physician who received his/her basic medical degree from a medical school located outside the United States and Canada*. Citizens of the United States who have completed their medical education in schools outside the United States and Canada are considered international medical graduates; non-U.S. citizens who have graduated from medical schools in the United States and Canada are not considered international medical graduates.

* The United States and Canada refer to the geographic locations where citizens are issued passports by the governments of either the United States or Canada.

**ECFMG Certification**

## Requirements for ECFMG Certification

To be eligible for certification by ECFMG, international medical graduates must meet the following requirements.

### Medical School Requirements

The physician's medical school must meet requirements established by ECFMG. Schools that meet all requirements will be listed in the *World Directory of Medical Schools (World Directory)* with an ECFMG note stating that the school meets eligibility requirements for their students and graduates to apply to ECFMG for ECFMG Certification and examination. The ECFMG note also will include the graduation years for which the school meets these requirements. Since ECFMG is a sponsor of the *World Directory*, the ECFMG note is located on the "Sponsor Notes" tab of the medical school listing. **If there is no ECFMG note on the Sponsor Notes tab of your medical school's listing, you are not eligible to apply to ECFMG for ECFMG Certification and examination.** To confirm that your medical school meets ECFMG's requirements, access the *World Directory* at [www.wdoms.org](www.wdoms.org) ↗.

> **Important Note:** Starting in 2024, ECFMG will begin implementation of the ECFMG Recognized Accreditation Policy. The policy links ECFMG Certification to the accreditation status of a medical school. For the latest information on the forthcoming policy, please monitor the ECFMG website at [www.ecfmg.org/accreditation](www.ecfmg.org/accreditation).

### Application for ECFMG Certification

To be eligible for ECFMG Certification, international medical students/graduates must submit an Application for ECFMG Certification, which confirms their intent to pursue ECFMG Certification and their understanding of the purpose of the certification program. The Application for ECFMG Certification consists of an on-line application and the *Certification of Identification Form* (Form 186), available via our [on-line services](on-line services). Among other things, the Application for ECFMG Certification requires applicants to confirm their identity, contact information, and graduation from or enrollment in a medical school that is listed in the *[World Directory](World Directory)* ↗ with an ECFMG note stating it meets ECFMG eligibility requirements. See *[Medical School Requirements](Medical School Requirements)* above and the *[Application for ECFMG Certification](Application for ECFMG Certification)* section for more information.

### Examination Requirements

**To meet the medical science examination requirement for ECFMG Certification,** applicants must pass Step 1 and Step 2 Clinical Knowledge (CK) of the United States Medical Licensing Examination (USMLE).

To meet the clinical skills requirement and communication skills requirement for **ECFMG Certification**, applicants must:

- Complete an ECFMG Pathway, which includes attaining a satisfactory score on the Occupational English Test (OET) Medicine, **OR**
- Have a passing performance on the former Step 2 Clinical Skills (CS) component of USMLE that is valid for ECFMG Certification.

ECFMG has established time limits and other rules for completing the examination requirements for ECFMG Certification. For detailed information, see *Examinations for ECFMG Certification*.

## Medical Education Credential Requirements

The physician's graduation year must be included in the ECFMG note in the medical school's *World Directory* listing. International medical graduates must have been awarded credit for at least four credit years (academic years for which credit has been given toward completion of the medical curriculum) by a medical school that is listed in the *World Directory* with an ECFMG note stating it meets ECFMG eligibility requirements. There are restrictions on credits transferred to the medical school that awards an applicant's medical degree that can be used to meet this requirement. See *ECFMG Policy on Transfer Credits* in *Medical Education Credentials*.

Applicants must document the completion of all requirements for, and receipt of, the **final medical diploma**. See the *Reference Guide for Medical Education Credentials* on the ECFMG website for the exact title of the final medical diploma you must have earned (and must provide). ECFMG verifies every applicant's medical school diploma with the appropriate officials of the medical school that issued the diploma and requests that the medical school provide the **final medical school transcript**. Verification by ECFMG with the issuing school may also be required for transcripts that are submitted to document transferred credits. See *Medical Education Credentials*.

> **Important Note:** Submitting falsified or altered documents may result in a finding of irregular behavior and permanent annotation of your record. For more information and potential consequences, see *Policies and Procedures Regarding Irregular Behavior*.

**ECFMG Certification**

## Standard ECFMG Certificate

ECFMG issues the Standard ECFMG Certificate to applicants who meet all of the requirements for certification. International medical graduates must also pay any outstanding charges on their financial accounts before their certificates are issued. Standard ECFMG Certificates are issued to applicants approximately two weeks after all of these requirements have been met. The date that the Standard ECFMG Certificate is issued is the date an international medical graduate is considered certified by ECFMG. Currently, ECFMG sends the Standard ECFMG Certificate to the applicant's address of record by Federal Express.

The Standard ECFMG Certificate includes:

- The name of the applicant;
- The certificate number;
- How the examination requirements were met;
- The date that the certificate was issued; and
- The valid through date, if applicable. See *Expiration of the ECFMG Certificate Based on a Pathway* below.

## Expiration of the ECFMG Certificate Based on a Pathway

If you met the clinical skills requirement and the communication skills requirement for ECFMG Certification through a Pathway, your ECFMG Certificate is subject to expiration. For detailed information on expiration of the ECFMG Certificate, refer to the Pathways in the ECFMG Certification section of the ECFMG website.

## Confirming ECFMG Certification to Third Parties

ECFMG offers the Certification Verification Service (CVS) to provide primary-source confirmation of the ECFMG certification status of international medical graduates. ECFMG will confirm your certification status when a request is received from a U.S. medical licensing authority, residency program director, hospital, or other organization that, in the judgment of ECFMG, has a legitimate interest in such information. For more information, see *Confirming ECFMG Certification to Third Parties* in *Related ECFMG Services*.

## Your Record

### USMLE/ECFMG Identification Number

Before you can submit an Application for ECFMG Certification or apply to ECFMG for an exam, you must obtain a USMLE/ECFMG Identification Number. You can obtain a USMLE/ECFMG Identification Number via our on-line services.

To obtain a USMLE/ECFMG ID, you must provide certain information, including your name as it appears on your current, unexpired passport; date of birth; address of residence; and medical school information. If ECFMG determines that the biographic information you submit is inaccurate, not complete, or insufficient to assign a USMLE/ECFMG Identification Number to you, your request for the USMLE/ECFMG Identification Number will not be processed. If you fail to provide your name exactly as it appears on your current, unexpired passport, you will be required to submit acceptable documentation, as described in *Changing Your Name* in *Your Record*, to change your name of record with us.

Once we inform you of your number, you must include it on all communications, applications, medical education credentials, request forms, and payments that you send to us.

You will only be assigned one USMLE Identification Number. Your USMLE Identification Number cannot be changed. Obtaining or attempting to obtain a USMLE/ECFMG Identification Number after one has been assigned to you may result in a finding of irregular behavior. If you forget or lose your USMLE/ECFMG Identification Number, you can obtain it via our on-line services or by contacting ECFMG. To protect the privacy of applicants, we will not provide USMLE/ECFMG Identification Numbers by telephone.

> **Important Note:** As part of the application processes, you will be asked if you previously submitted an Application for ECFMG Certification and/or an application for examination to ECFMG. You also will be asked if you were previously assigned a USMLE Identification Number. If you were previously assigned a USMLE Identification Number or have submitted a prior application to ECFMG, you must answer "Yes" to the applicable question(s), even if you submitted the prior application under a different name or did not take the exam for which you applied. You must answer "Yes" regardless of whether you submitted an on-line application or a paper application. If you were previously assigned a USMLE Identification Number or have submitted an application to ECFMG but indicate that you were not previously assigned a number or have not applied previously, this may result in a finding of irregular behavior and permanent annotation of your record. See *Policies and Procedures Regarding Irregular Behavior*.

# Your Record

## Your Name

You must ensure that your name of record with us matches your name exactly as it appears on your current, unexpired passport. Your name of record will appear on your Standard ECFMG Certificate once you have met all requirements for certification. You must use this name consistently in all communications you send to us, including applications and requests for other services. Failure to use your name of record consistently in all communications with us may delay exam registration. It may also prevent you from taking an exam for which you are registered and scheduled.

You can check your name of record via our on-line services. If the name in your record does not match your name exactly as it appears on your passport, you must follow our established process to request a **change** in your name of record. See *Changing Your Name* in *Your Record*.

- Your name of record will appear on your exam **scheduling permit**. Your name, as it appears on your scheduling permit, must exactly match the name on the form(s) of **identification** you present at the test center. The only acceptable differences are variations in capitalization; the presence of a middle name, middle initial or suffix on one document and its absence on the other; or the presence of a middle name on one and middle initial on the other. Please review your scheduling permit for additional details. See information on required identification under *Taking the Examination* in *The United States Medical Licensing Examination (USMLE)*.
- If the name on your **scheduling permit** has been misspelled, contact ECFMG immediately. Use the contact information for General Inquiries on the Contact ECFMG page of the ECFMG website.
- If you change your name of record while you are registered for an exam, a revised scheduling permit reflecting this change will be issued. ECFMG will send your revised scheduling permit via e-mail. You must present the revised scheduling permit at the test center on your exam date. Name changes must be received **and processed** by ECFMG no later than seven business days before your testing appointment, or you will not be able to test.
- If you have a valid *Certification of Identification Form* (Form 186) on file with us, it will be invalidated when your name of record is changed, and you will be required to complete a new *Certification of Identification Form* (Form 186) before you may apply for examination.
- If the name on your **medical diploma, transcript, or other credential** does not match **exactly** the name in your **record**, you must submit documentation, as described in *Verifying Your Name* in *Medical Education Credentials* that **verifies** the name on your medical diploma, transcript, or other credential is (or was) your name.

**Your Record**

## Changing Your Name

If your name of record does not match your name exactly as it appears on your current, unexpired passport, you must follow our established process to request a **change** of name in your record. You will be required to provide a reason for the name change, as well as supporting documentation. Additional information and instructions are provided with the [form](#).

> **Important Notes:** If you change your name of record while you are registered for an exam, a revised scheduling permit reflecting this change will be issued. ECFMG will send your revised scheduling permit via e-mail. You must present the revised scheduling permit at the test center on your exam date. Name changes must be received **and processed** by ECFMG no later than seven business days before your testing appointment, or you will not be able to test.

> If you have a valid *Certification of Identification Form* (Form 186) on file with us, it will be invalidated when your name of record is changed, and you will be required to complete a new *Certification of Identification Form* (Form 186) before you may apply for examination.

## Your Record

### Contact Information

The contact information in your record with us consists of your e-mail address, your address of residence, and your phone number. We will use your address of residence as your mailing address. Certain ECFMG correspondence, including your Standard ECFMG Certificate, requires a full mailing address.

You should ensure that the contact information in your record is current. You can check and update your contact information via our on-line services. You cannot submit changes to your contact information by e-mail. We will not process changes to contact information received from any person other than the applicant.

Changing your e-mail address of record does not update your e-mail address in your e-newsletter subscription(s). You can change your e-newsletter subscription preferences via the ECFMG website.

To protect the privacy of applicants, ECFMG will e-mail applicant-specific information only to the applicant's e-mail address of record. If your e-mail inquiry requires a specific response, you must send your inquiry from the e-mail address in your record.

For further information regarding our data collection and privacy practices, please refer to our Privacy Notice.

## Your Record

## Your Financial Account

You can access your financial account with us via our on-line services.

For a list of fees for ECFMG services that applicants encounter most frequently while pursuing ECFMG Certification and entry into U.S. programs of graduate medical education, see the Fees and Payment section of the ECFMG website. You should also read and become familiar with the information on payment, acceptable methods of payment, refunds, and forfeiture of funds in that section.

# Your Record

## Irregular Behavior

### A. Policies Regarding Irregular Behavior

1. *Irregular behavior* includes all actions or attempted actions on the part of applicants, examinees, potential applicants, others when solicited by an applicant and/or examinee, a medical school official, or any other person or entity that would or could subvert the examination, certification or other processes, programs, or services of ECFMG, including, but not limited to, the ECFMG Exchange Visitor Sponsorship Program, ECFMG International Credentials Services (EICS), the Electronic Portfolio of International Credentials (EPIC), and Electronic Residency Application Service (ERAS) Support Services at ECFMG. Such actions or attempted actions are considered irregular behavior, regardless of when the irregular behavior occurs, and regardless of whether the individual committing the action is certified by ECFMG or eligible for ECFMG Certification and in the case of a medical school, regardless of whether a medical school official is also charged. Examples of irregular behavior include, but are not limited to, submission of any falsified or altered document to ECFMG, whether submitted by the individual or by a third party, such as a medical school or other entity, on behalf of the individual; failing to comply with United States Medical Licensing Examination® (USMLE®) or ECFMG policies, procedures, and/or rules; falsification of information on applications, submissions, or other materials to ECFMG; taking an examination when not eligible to do so, submission of any falsified or altered ECFMG document to other entities or individuals; a medical school providing false information to ECFMG regarding its students or a medical school providing misleading information to its students regarding ECFMG Certification.

2. The Medical Education Credentials Committee's determination of irregular behavior is sufficient cause for ECFMG to bar an individual from future examinations, to bar an individual from other ECFMG programs and services, to withhold and/or invalidate the results of an examination, to withhold an ECFMG Certificate, to revoke an ECFMG Certificate, or to take other appropriate actions for a specified period of time or permanently. The Medical Education Credentials Committee's determination of irregular behavior is also sufficient cause for ECFMG to remove a Sponsor Note from the *World Directory of Medical Schools* in accordance with its Medical School Requirements for ECFMG Certification Eligibility Policy and Procedures (aka "ECFMG Medical School Listing Policy") for a specified period of time or permanently or to take other appropriate actions. ECFMG may report the Medical Education Credentials Committee's determination of irregular behavior to the USMLE Committee for Individualized Review, Federation of State Medical Boards of the United States, U.S. state and international medical licensing authorities, directors of graduate medical education programs, and to any other organization or individual who, in the sole judgment of ECFMG, has a legitimate interest in such information.

3. If the Medical Education Credentials Committee determines that an individual engaged in irregular behavior, a permanent annotation to that effect will be included in the individual's ECFMG record. This annotation will appear on the ECFMG Certification Verification Service (CVS) and ECFMG Status Reports

for the individual. If the individual has an EPIC Portfolio, a permanent annotation will be included on all EPIC Reports with respect to that individual. Additional information explaining the basis for the determination of irregular behavior and the resulting action(s) will accompany every ECFMG Status Report, CVS Report, and EPIC Report, and may also be provided to legitimately-interested entities; this additional information may be provided, regardless of the date of the conduct or activity that comprises the irregular behavior.

4. If the Medical Education Credentials Committee determines that a medical school has committed irregular behavior, ECFMG may remove its Sponsor Note for the medical school in accordance with the ECFMG Medical School Listing Policy. ECFMG may report the determination of irregular behavior to any organization or individual who, in the sole judgment of ECFMG, has a legitimate interest in such information.

5. Notice of the Medical Education Credentials Committee's determination of irregular behavior is periodically reported to the ECFMG Board of Trustees.

## B. Procedures Regarding Irregular Behavior

1. After receipt of a report or other information suggesting irregular behavior on the part of an individual or entity, ECFMG staff will review the information and will assess whether there is sufficient evidence of irregular behavior to proceed with an investigation. When indicated and feasible, staff will conduct a follow-up investigation to gather additional information.

2. If the individual is an examinee and the review referenced above will not be concluded until after the typical period for the reporting of exam scores, the examinee will be notified that the reporting of the exam scores in question is being delayed.

3. If the ECFMG staff finds that there exists a reasonable basis to conclude that an individual or entity may have engaged in irregular behavior, the matter will be referred to the Medical Education Credentials Committee. ECFMG may withhold services from the individual or entity pending a determination from the Medical Education Credentials Committee. If the individual referred is an examinee, the examinee's exam scores will be withheld, if not already released, and the examinee may not be permitted to sit for subsequent examinations, nor will applications for examination be processed. If the individual referred is an applicant for J-1 Sponsorship with the ECFMG Exchange Visitor Sponsorship Program or is currently being sponsored by ECFMG, ECFMG will notify the United States Department of State of the pending allegation if required to do so by regulation. If a school or other academic institution is referred, ECFMG may implement additional requirements on the school and its students to demonstrate that it has the staff, policies/procedures, and facilities necessary for the school's students and graduates to fulfill ECFMG's requirements to become ECFMG certified and/or take such other measures to protect the health and safety of the public.

4. Concurrent with the referral to the Medical Education Credentials Committee, the individual or entity will be advised in writing of the nature of the alleged irregular behavior and will be provided with a copy of the *Policies and Procedures Regarding Irregular Behavior*. If the alleged irregular behavior is related to a shared ECFMG and USMLE policy, the USMLE Program will also be advised of the allegation. The individual/entity will be given an opportunity to provide written explanation and to present other relevant information. Any such written explanation or other relevant information must be received by ECFMG by the deadline communicated to the individual/entity. Submissions received after the deadline will be considered by the Medical Education Credentials Committee at its discretion. The individual/entity may also request the opportunity to appear in person before the Medical Education Credentials Committee, and may be represented by legal counsel, if desired. For in-person appearances before the Medical Education Credentials Committee, a stenographic or audio recording will be made of that portion of the proceedings during which the individual/representative(s) for the entity are in attendance. Any statements made by the individual or individual(s) representing the entity during an in-person appearance before the Medical Education Credentials Committee will be under oath. All hearings involving applicants for ECFMG's certification program will be held in English and interpreters will not be permitted. For hearings involving applicants to ECFMG's other programs and services, ECFMG will allow an interpreter if obligated to provide services in languages other than English. In these circumstances, if an interpreter is desired, the applicant must request one in writing by the response deadline outlined in ECFMG's letter to the applicant. ECFMG will then provide the interpreter. All in- person hearings for entities charged with irregular behavior will be conducted in English and interpreters will not be permitted.

5. Individuals/entities charged with irregular behavior who wish to request a deferral of the ECFMG Committee's review of the allegation must (1) submit the request in writing and (2) provide the reason for the request. If ECFMG staff determine that the granting of the request could have a material impact on the individual's or entity's opportunity to refute the allegation then staff, at its discretion, can grant the request and defer an ECFMG action for up to six (6) months. Unless the individual/entity can demonstrate compelling circumstances, ECFMG staff should not grant more than two deferral requests. Notwithstanding the foregoing, if the individual charged with irregular behavior is ECFMG Certified, a candidate for residency, or practicing medicine, or if the entity is a medical school, ECFMG staff will only grant the request for deferral if, in its sole discretion, ECFMG believes that public health and safety is not at risk. If the deferral request is granted, ECFMG will notify appropriate institutions and authorities of the individual's or entity's pending irregular behavior charge.

6. All pertinent information regarding the irregular behavior, including any explanation or other information that the individual/entity may provide, will be provided to the Medical Education Credentials Committee. The Medical Education Credentials Committee, based on the information available to it, will determine whether the preponderance of the evidence indicates that the individual/entity engaged in irregular behavior. If the Medical Education Credentials Committee determines that the individual/entity engaged in irregular behavior, the Medical Education Credentials Committee will determine what action(s) will be taken as a result of the irregular behavior. ECFMG will notify the individual/entity whether the Medical Education Credentials Committee determined the individual engaged in irregular behavior and of any action(s) taken pursuant thereto.

7. The Medical Education Credentials Committee's determination of irregular behavior and any action(s) taken pursuant thereto (a "decision" of the Medical Education Credentials Committee) may be appealed to the Review Committee for Appeals if the individual/entity has a reasonable basis to believe the Medical Education Credentials Committee did not act in compliance with the Medical Education Credentials Committee Policies and Procedures or that the Medical Education Credentials Committee's decision was clearly contrary to the weight of the evidence before it. The notice of appeal must be received by ECFMG within thirty (30) days of the date on which the notification advising the individual of the Medical Education Credentials Committee's decision was mailed to the individual. The appeal of a decision of the Medical Education Credentials Committee is governed by the Medical Education Credentials Committee's Rules of Appellate Procedure.

8. Petitions for reconsideration of a decision of the Medical Education Credentials Committee will be reviewed by the Medical Education Credentials Committee only in extraordinary cases. Any such petition must first be considered by ECFMG staff, who, after discussion with the Medical Education Credentials Committee Chair, may deny the request or place it on the agenda for consideration by the full Medical Education Credentials Committee at a regularly scheduled meeting. Absent the submission of newly discovered material evidence not previously available to the petitioner and, therefore, not available to the Medical Education Credentials Committee, petitions for reconsideration typically will be denied. Generally, ECFMG will not consider as newly discovered evidence actions that the individual/entity has taken after the irregular behavior has occurred and/or after the finding of irregular behavior by the Medical Education Credentials Committee.

## C. Representative Examples of Irregular Behavior

Representative examples of allegations of irregular behavior and actions taken by the ECFMG Medical Education Credentials Committee include, but are not limited to, the following:

- **Providing false information on an application submitted to ECFMG**

   The ECFMG Medical Education Credentials Committee reviewed an allegation of irregular behavior in connection with an individual who provided false information on an application submitted to ECFMG as part of the certification process. In that application, the individual certified he was a student enrolled in medical school when, in fact, he previously had been dismissed from medical school and, therefore, was no longer a student.

   Following review, the ECFMG Medical Education Credentials Committee determined the individual had engaged in irregular behavior and **took action to bar the individual from ECFMG Certification, thereby rendering the individual ineligible to apply for USMLE examinations leading to ECFMG Certification. A permanent annotation was added to the individual's record.**

- **Providing false information to ECFMG as part of the ECFMG On-line Authentication Process, which is a prerequisite to submitting an application for examination**

   The ECFMG Medical Education Credentials Committee reviewed an allegation of irregular behavior in connection with an individual who provided false information to ECFMG as part of the ECFMG On-line Authentication Process, which is used to obtain a USMLE/ECFMG Identification Number and is a prerequisite to submitting an application for examination. During the on-line authentication process,

the individual certified he had not previously submitted an application for examination to ECFMG when he had not only previously applied for, but had taken examinations.

Following review, the ECFMG Medical Education Credentials Committee determined the individual had engaged in irregular behavior and **took action to bar the individual from ECFMG Certification, thereby rendering the individual ineligible to apply for USMLE examinations leading to ECFMG Certification. A permanent annotation was added to the individual's record.**

- **Submitting a fraudulent medical diploma and providing false information on an application submitted to ECFMG**

    The ECFMG Medical Education Credentials Committee reviewed an allegation of irregular behavior in connection with an individual who submitted a fraudulent medical diploma and provided false information on an application submitted to ECFMG.

    Following review, the ECFMG Medical Education Credentials Committee determined the individual had engaged in irregular behavior and **took action to bar the individual from ECFMG Certification, thereby rendering the individual ineligible to apply for USMLE examinations leading to ECFMG Certification. A permanent annotation was added to the individual's record.**

- **Submitting a falsified medical school transcript and providing false information to ECFMG**

    The ECFMG Medical Education Credentials Committee reviewed an allegation of irregular behavior in connection with an authorized medical school official who submitted a fraudulent medical school transcript and provided false information to ECFMG.

    Following review, the ECFMG Medical Education Credentials Committee determined the authorized medical school official had engaged in irregular behavior and **determined that ECFMG will not accept any documents signed and/or certified by the medical school official for ECFMG on behalf of the medical school, or any other medical school, for a minimum of five years. A permanent annotation was added to the medical school official's record.**

- **Submitting a falsified passport and providing false information on an application submitted to ECFMG**

    The ECFMG Medical Education Credentials Committee reviewed an allegation of irregular behavior in connection with an individual who submitted a falsified passport and provided false information on an application submitted to ECFMG.

    Following review, the ECFMG Medical Education Credentials Committee determined that the individual had engaged in irregular behavior. **A permanent annotation was added to the individual's record.**

# Application for ECFMG Certification

## Application for ECFMG Certification

To be eligible for ECFMG Certification, you must complete an Application for ECFMG Certification, which confirms your intent to pursue ECFMG Certification and your understanding of the purpose of the certification program. The Application for ECFMG Certification consists of an on-line application and the *Certification of Identification Form* (Form 186) that must be completed and notarized via NotaryCam. You should read the detailed instructions for the application before you begin working on it. Instructions on how to complete Form 186 using NotaryCam are included with the form. You must have your *USMLE/ECFMG Identification Number* before you can begin the Application for ECFMG Certification. For the current fee for submitting an Application for ECFMG Certification, see the Fees page of the ECFMG website.

As part of the Application for ECFMG Certification, you will be asked to confirm the name, date of birth, and gender in your record with us. If this information does not match exactly the information on your current, unexpired passport, you must have the information in your record changed to reflect the information as it appears on your passport before you can complete the Application for ECFMG Certification. Instructions for how to correct this information will be provided at the time of application.

If you are a medical school **student**, you will be asked to confirm that you are officially enrolled in a medical school located outside the United States and Canada that is listed in the *World Directory* ⬈ with an ECFMG note stating it meets ECFMG eligibility requirements, and that the "Graduation Years" in the ECFMG note in your medical school's *World Directory* listing are listed as "Current." If you are a medical school **graduate**, you will be asked to confirm that you are a graduate of a medical school located outside the United States and Canada that is listed in the *World Directory* with an ECFMG note stating it meets ECFMG eligibility requirements, and that your graduation year is included in the ECFMG note in your school's *World Directory* listing. See *Medical School Requirements*.

An Application for ECFMG Certification will not be considered complete until ECFMG receives and processes both the on-line part of the application and the notarized Form 186 from NotaryCam. Once your Application for ECFMG Certification, including Form 186, has been accepted by ECFMG, it typically remains valid throughout the certification process. You can use our on-line services to confirm that you have submitted an Application for ECFMG Certification and have a valid Form 186 on file.

# Examinations for ECFMG Certification

## Examination Requirements

To be eligible for ECFMG Certification, you must satisfy the medical science examination requirement, the clinical skills requirement, and the communication skills requirement. ECFMG has established time limits for completing these examination requirements for ECFMG Certification. See _Time Limit for Completing Examination Requirements_ in _Examinations for ECFMG Certification._

## Medical Science Examination Requirement

To satisfy the medical science examination requirement for ECFMG Certification, you must pass Step 1 and Step 2 Clinical Knowledge (CK) of the United States Medical Licensing Examination (USMLE). Refer to the USMLE _Bulletin of Information_ for more information.

## Clinical Skills Requirement and Communication Skills Requirement

To satisfy the clinical skills requirement and the communication skills requirement for ECFMG Certification, you must:

- Complete an ECFMG Pathway, which includes attaining a satisfactory score on the Occupational English Test (OET) Medicine, **OR**
- Have a passing performance on the former Step 2 Clinical Skills (CS) component of USMLE that is valid for ECFMG Certification.

For detailed information on the Pathways, refer to the ECFMG Certification section of the ECFMG website. The Pathways allow qualified IMGs to meet the clinical skills and communication skills requirements for ECFMG Certification and to compete for positions in U.S. graduate medical education. The Pathways are offered on a seasonal application cycle, and IMGs should consider the timing of their applications carefully. For example, if you need to meet the clinical skills and communication skills requirements for ECFMG Certification and you plan to participate in the 2023 NRMP Match in March 2023, you should apply to one of the 2023 Pathways. If you plan to participate in a future Match, you should monitor the ECFMG website for information on future requirements.

IMGs also should be aware that ECFMG Certificates issued based on a Pathway are subject to expiration. See _Standard ECFMG Certificate_ in _ECFMG Certification_ for more information.

> **Important Note:** Prior to its discontinuation by the USMLE program in 2020, Step 2 CS was the exam that satisfied the clinical skills and communication skills requirements for ECFMG

Certification. A passing performance on the former Step 2 CS component of USMLE that is valid for ECFMG Certification still satisfies the clinical skills and communication skills requirements. This means that, if you have a passing performance on Step 2 CS that is valid for ECFMG Certification, you do not have to (and are not eligible to) pursue a Pathway.

## Certain Former Exams Not Accepted

All international medical graduates pursuing ECFMG Certification must meet the current examination requirements. Passing performance on the following former examinations cannot be used to meet the examination requirements for ECFMG Certification:

- ECFMG Examination;
- Federation Licensing Examination (FLEX);
- Visa Qualifying Examination (VQE);
- Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS);
- NBME Part I and Part II; and
- ECFMG Clinical Skills Assessment (CSA).

# Examinations for ECFMG Certification

## Time Limit for Completing Examination Requirements

ECFMG requires that international medical graduates satisfy the examination requirements for ECFMG Certification within a seven-year period. This means that once you pass an exam, you will have seven years to pass the other exam(s) required for ECFMG Certification. This seven-year period begins on the date of the first exam passed and ends **exactly seven years from that date**.

**Important Note:** Applicants who satisfy the clinical skills requirement and the communication skills requirement through a Pathway are subject to this seven-year requirement. This means that your Pathways application must be accepted within the seven-year period. If your Pathways application is not accepted within the seven-year period and you have a passing Step 1 and/or Step 2 CK score that becomes invalid for ECFMG Certification as a result, you must contact ECFMG to determine whether your invalid passing performance on Step 1 and/or Step 2 CK meets ECFMG's requirements to be extended.

If you do not satisfy all examination requirements within a maximum of seven years, your earliest USMLE passing performance will no longer be valid for ECFMG Certification. **It is your responsibility to track your progress toward meeting the exam requirements for ECFMG Certification. ECFMG will not notify you of upcoming deadlines to meet the seven-year requirement and will not notify you if one (or more) of your passing performances becomes invalid for ECFMG Certification because you failed to meet the seven-year requirement.**

**Examples:** An international medical graduate passed Step 1 on January 20, 2016 and Step 2 CS on February 20, 2019. He has through January 20, 2023 to take and pass Step 2 CK to satisfy the remaining exam requirements for ECFMG Certification. If he does not take and pass Step 2 CK on or before January 20, 2023, his passing performance on Step 1 would no longer be valid for ECFMG Certification.

An international medical graduate passed Step 1 on November 30, 2015 and Step 2 CK on March 20, 2019. She has through November 30, 2022 to satisfy the clinical skills and communication skills requirements for ECFMG Certification through a Pathway. If she does not have an accepted Pathways application on record by November 30, 2022, her passing performance on Step 1 will no longer be valid for ECFMG Certification.

Under this ECFMG requirement, more than one USMLE passing performance can become invalid for ECFMG Certification.

**Example:** An international medical graduate passed Step 1 on April 1, 2015, and passed Step 2 CS on May 1, 2016. She had through April 1, 2022 (seven years from her Step 1 passing performance) to pass Step 2 CK, satisfying the remaining exam requirements for ECFMG Certification. She did not pass Step 2 CK by April 1, 2022, so her passing performance on Step 1 is no longer valid for ECFMG Certification. Her earliest USMLE passing performance that is valid for ECFMG Certification is now the Step 2 CS passing performance on May 1, 2016. She now has through May 1, 2023 (seven years from her Step 2 CS passing performance) to pass Step 1 and Step 2 CK, satisfying the remaining exam requirements for ECFMG Certification. If she does not pass Step 1 and Step 2 CK by May 1, 2023, her passing performance on Step 2 CS will no longer be valid for ECFMG Certification.

If you have passed a Step but this passing performance is no longer valid for ECFMG Certification, you may request an exception to retake the previously passed exam that is no longer valid. The USMLE program limits to four the total number of times an examinee can take the same Step. See *Reexamination and Reapplication* in *The United States Medical Licensing Examination (USMLE)*.

**Important Notes:** Time limits to complete the USMLE for the purpose of U.S. medical licensure are established by state medical licensing authorities and may require completion of all Steps (including Step 3, which is not required for ECFMG Certification) within a certain number of years. Information regarding specific state requirements can be obtained on the Federation of State Medical Boards website ↗.

Applicants who retake a previously passed Step to comply with a time limit should understand the implications of a failing retake performance on their Step 3 eligibility. See *Retaking Previously Passed Steps* in the USMLE *Bulletin of Information*.

A passing performance that is no longer valid for ECFMG Certification will still appear on a USMLE transcript.

## Eligibility for Examination

The eligibility requirements for examination differ depending on whether you are an international medical school **student** or an international medical school **graduate**.

## International Medical School Students

**To be eligible for Step 1 and Step 2 Clinical Knowledge (CK)**, you must be officially enrolled in a medical school located outside the United States and Canada that is listed in the _World Directory_ ☒ with an ECFMG note stating it meets ECFMG eligibility requirements, both at the time that you apply for examination and on your test day. In addition, the "Graduation Years" in the ECFMG note in your medical school's _World Directory_ listing must be "Current" at the time you apply and on your test day. See Medical School Requirements. An authorized official of your medical school must certify your current enrollment status; instructions will be provided at the time of application for examination.

As soon as you graduate and receive your medical diploma, you must submit a copy of your medical diploma to ECFMG. See _Final Medical Diploma and Transcript_ in _Medical Education Credentials_.

**In addition to being currently enrolled as described above, to be eligible for Step 1 and Step 2 CK**, you must have completed at least two years of medical school. This eligibility requirement means that you must have completed the basic medical science component of the medical school curriculum by the beginning of your eligibility period. Although you may apply for and take the examinations after completing the basic medical science component of your medical school curriculum, it is recommended that you complete your core clinical clerkships, including actual patient contact, before taking Step 2 CK.

> **Important Notes:** If your eligibility for an exam changes after you apply but before you take the exam, you are required to inform ECFMG immediately in writing of this change in your status. Such notification must be sent to ECFMG's Applicant Information Services. Use the contact information for General Inquiries on the Contact ECFMG page of the ECFMG website. Such changes in your eligibility status include, but are not limited to, the following:

- Medical school students who transfer to another medical school after submitting an application for examination must inform ECFMG immediately in writing of this transfer.
- Medical school students who have been dismissed or withdraw(n) from medical school are not eligible for USMLE, even if they are appealing the school's decision to dismiss them or are otherwise contesting their status. Medical school students who have been dismissed or withdraw(n) from medical school must inform ECFMG immediately in writing of their dismissal or withdrawal.

- Medical school students who take a leave of absence should consult with their medical schools about whether they will be considered officially enrolled in medical school during leave. Your medical school may consider a student on leave of absence to be withdrawn from medical school. Medical school students who are not officially enrolled in medical school are not eligible to apply for or take USMLE. Applicants who take a leave of absence after submitting an application for examination to ECFMG must inform ECFMG immediately in writing of this leave.

**Failure to inform ECFMG that you may no longer be eligible to take the examination may result in a finding of irregular behavior and permanent annotation of your record. See** *Policies and Procedures Regarding Irregular Behavior*.

If you take a Step for which you are not eligible, results for that exam may not be reported or, if previously reported, may be canceled.

## Eligibility for Examination

The eligibility requirements for examination differ depending on whether you are an international medical school **student** or an international medical school **graduate**.

### International Medical School Graduates

**To be eligible for Step 1 and Step 2 CK**, you must be a graduate of a medical school located outside the United States and Canada that is listed in the *World Directory* 🗗 with an ECFMG note stating it meets ECFMG eligibility requirements. Your graduation year must be included in the "Graduation Years" listed in the ECFMG note in your medical school's *World Directory* listing. See *Medical School Requirements*. You must have been awarded credit for at least four credit years (academic years for which credit has been given toward completion of the medical curriculum) by a medical school that is listed in the *World Directory* with an ECFMG note stating it meets ECFMG eligibility requirements. An authorized official of your medical school must certify your status as a graduate of the school; instructions will be provided at the time of application.

You must submit a copy of your medical diploma at the time of exam application if your diploma has not been sent to ECFMG previously. The exact degree title of the final medical diploma you must have earned (and must provide) in order to be eligible for ECFMG Certification and the examinations required for Certification is listed in the *Reference Guide for Medical Education Credentials* on the ECFMG website. If you have graduated and met all requirements for your medical diploma but your medical diploma has not yet been issued, a letter signed by an authorized official of your medical school must be submitted with your exam application. The letter you submit must be the original document and must be written on your medical school's letterhead. The letter must include the following statement:

> **This is to confirm that [applicant name] has graduated and completed all requirements to receive the [degree title] degree from [medical school/university name]. The degree will be issued [month and year].**

You must then submit a copy of your medical diploma to ECFMG as soon as your diploma is issued. See *Medical Education Credentials*.

All documents that are not in English must be accompanied by an official English translation that meets ECFMG's translation requirements. See *English Translations* in *Medical Education Credentials*.

**All credentials and documentation required to complete your exam application must be received within four weeks of the date you submit the on-line portion of your application, or your exam application will be rejected.**

**Important Notes:** If your eligibility for an exam changes after you apply but before you take the exam, you are required to inform ECFMG immediately in writing of this change in your status. Such notification must be sent to ECFMG's Applicant Information Services. Use the contact information for General Inquiries on the Contact ECFMG page of the ECFMG website. **Failure to inform ECFMG that you may no longer be eligible to take the examination may result in a finding of irregular behavior and permanent annotation of your record. See** *Policies and Procedures Regarding Irregular Behavior*.

If you take a Step for which you are not eligible, results for that exam may not be reported or, if previously reported, may be canceled.

If you have already been granted a physician license by a U.S. medical licensing authority based on other licensure examinations, such as the Federation Licensing Examination (FLEX), the Medical Council of Canada Qualifying Examination, NBME certifying examinations, or the National Board of Osteopathic Medical Examiners COMLEX-USA, you may not be eligible to take the USMLE. Please contact ECFMG if you have questions about your eligibility.

# Eligibility for Examination

## Reverification of Eligibility

ECFMG reserves the right to reverify your eligibility for examination at any time during the application and registration process. If your medical school informs ECFMG that your status has changed, and ECFMG determines you are no longer eligible for examination, your registration will be canceled. **If you have failed to inform ECFMG of this change in your status, it may result in a finding of irregular behavior and permanent annotation of your record. See** *Policies and Procedures Regarding Irregular Behavior*.

For medical school students, ECFMG may reverify your status as a student officially enrolled in medical school. If reverification is requested by ECFMG, ECFMG may cancel your registration or withhold your score report until ECFMG has received reverification of your status directly from the medical school. If your registration is canceled, you may be required to reapply.

For medical school graduates, ECFMG may reverify your medical education credentials with the issuing medical school. If such reverification is requested by ECFMG, you will be registered for examination only after ECFMG has received reverification of your credentials directly from the medical school. If reverification is requested by ECFMG after you have been registered for examination, ECFMG may cancel your registration or withhold your score report until ECFMG has received reverification of your medical education credentials directly from the issuing school. If your registration is canceled, you may be required to reapply.

# The United States Medical Licensing Examination (USMLE)

## About USMLE

The USMLE is a three-step examination for medical licensure in the United States. The USMLE provides a common system to evaluate applicants for medical licensure. The USMLE is sponsored by the Federation of State Medical Boards (FSMB) ☑ and the National Board of Medical Examiners (NBME) ☑.

To learn more, visit the USMLE website ☑.

If you apply for examination, you are **required** to read the USMLE *Bulletin of Information* for detailed information on the USMLE.

# The United States Medical Licensing Examination (USMLE)

## Registration and Test Delivery Entities

### Step 1 and Step 2 Clinical Knowledge (CK)

ECFMG is the organization that registers international medical students/graduates for Step 1 and Step 2 CK. This means that ECFMG processes your exam application and payment, verifies your eligibility, and notifies you of the outcome of your application. The NBME serves as the registration entity for students/graduates of U.S. and Canadian medical school programs accredited by the Liaison Committee on Medical Education (LCME)🗗 and U.S. medical schools accredited by the Commission on Osteopathic College Accreditation (COCA)🗗.

For eligible international medical students/graduates applying for Step 1/Step 2 Clinical Knowledge (CK), ECFMG forwards registration information to NBME, and NBME issues the exam scheduling permits. ECFMG sends these applicants their scheduling permits via e-mail. Scheduling and test centers for USMLE Step 1 and Step 2 CK are provided by Prometric🗗. Prometric serves as the test delivery entity for all examinees taking Step 1/Step 2 CK. Step 1 and Step 2 CK are delivered at Prometric test centers worldwide.

For all applicants, NBME is responsible for determining the results of USMLE exams and for issuing the score reports. ECFMG sends an e-mail notification to international medical students/graduates when their Step 1 and Step 2 CK score reports are available.

## Step 3

The FSMB is the organization that registers all Step 3 applicants. To be eligible for Step 3, international medical graduates must be certified by ECFMG, among other requirements. See *Eligibility for the USMLE Steps* in the USMLE *Bulletin of Information*. If you have not met all eligibility requirements, your application for Step 3 will not be accepted. For detailed information and application procedures for Step 3, contact the FSMB🗗. Scheduling and test centers for Step 3 are provided by Prometric🗗, which serves as the test delivery entity for all Step 3 examinees. USMLE Step 3 is delivered at Prometric test centers in the United States.

For all applicants, NBME is responsible for determining the results of USMLE exams and for issuing the score reports. FSMB notifies examinees when their Step 3 score reports are available.

# The United States Medical Licensing Examination (USMLE)

## Applying for Examination

Before applying to ECFMG for examination:

- International medical students/graduates must complete an Application for ECFMG Certification, including the notarized *Certification of Identification Form* (Form 186). See *Application for ECFMG Certification*.
- ECFMG must accept the Application for ECFMG Certification, including the notarized Form 186.
- International medical students/graduates must read the applicable editions of the ECFMG *Information Booklet* and the USMLE *Bulletin of Information*.

**Important Note:** Please note that ECFMG will not provide services of any kind if doing so would be considered violative of any applicable international, federal, state, or local laws or regulations. Additionally, ECFMG may delay or suspend provision of services while investigating whether the services or surrounding circumstances violate such laws, regulations, or ECFMG's policies and procedures.

You can apply for USMLE Step 1 and/or Step 2 CK via our on-line services. You should read the detailed instructions for the application for examination before you begin working on the application; these resources will help you plan the timing of your application and outline any necessary items (such as forms that must be completed by your medical school) that require advance planning.

**Important Note:** You should also consider deadlines imposed by the National Resident Matching Program (NRMP) ↗ and graduate medical education (GME) programs. It is solely the responsibility of the applicant to complete the exam requirements in time to meet deadlines imposed by the NRMP and/or GME programs. Since the number of applicants seeking to complete exams may exceed the spaces available in time to meet those deadlines, there is no guarantee that sufficient spaces will be available for all applicants to meet deadlines imposed by the NRMP and/or GME programs. ECFMG assumes no liability of any kind if an applicant does not complete the exam requirements in time to have results available to meet NRMP and/or GME program deadlines. See *Examination Results* for information on scoring turnaround times.

## Exam Fees

For Step 1 or Step 2 CK , there is an examination fee. Each exam also has an additional international test delivery surcharge if you choose a testing region other than the United States/Canada. You must pay all

applicable fees at the time you apply for examination. For the current exam fees and international test delivery surcharges, see the Fees page on the ECFMG website.

## Eligibility Periods

When you apply for Step 1 or Step 2 CK, you must select an eligibility period during which you would prefer to take the exam. The eligibility period you are assigned will be listed on your scheduling permit. You must take the exam during the eligibility period assigned to you.

If you are unable to take Step 1/Step 2 CK during the eligibility period assigned to you, you may request a one-time, contiguous eligibility period extension via our on-line services. Additional information and instructions are provided with the application.

**If you do not take Step 1/Step 2 CK during your original or extended eligibility period or if you are unable to extend your eligibility period, you must reapply by submitting a new application and fee(s), if you wish to take the exam.**

## Testing Locations

Step 1 and Step 2 CK are delivered at Prometric test centers worldwide. Prometric's test centers are grouped into defined testing regions. When you apply for Step 1 or Step 2 CK, you must choose the testing region where you want to take the exam. A list of Prometric testing regions is available on the ECFMG website.

You can take the exam at any test center in your testing region that offers USMLE, provided there is space available on the date you choose. **The test centers available for USMLE Step 1 and Step 2 CK are subject to change.** To obtain current information on specific test centers, visit the Prometric website [↗] or follow instructions on the scheduling permit for contacting Prometric.

If you are unable to keep your Step 1 or Step 2 CK testing appointment at the test center you select, you can reschedule for a different test center within your testing region, subject to availability. Rescheduling fees may apply. A fee schedule is posted on the USMLE website [↗]. Refer to your scheduling permit for details.

If you are unable to take Step 1 or Step 2 CK in the testing region you selected, you may request a change to your testing region. Additional information and instructions are provided with the form.

## Examinees with Disabilities Requesting Test Accommodations

The USMLE program provides reasonable accommodations for examinees with disabilities under the Americans with Disabilities Act (ADA). If you are an individual with such a disability and require test

accommodations, visit the USMLE website ↗ before you apply for each Step for information regarding test accommodations, including procedures and documentation requirements.

## Requesting Additional Break Time Only

Examinees who require additional break time for medical conditions, such as diabetes, or for other reasons, like use of a breast pump for lactation, may apply for additional break time/standard testing time. See the USMLE *Bulletin of Information* for more information.

## Personal Item Exceptions

Possession of personal items other than your locker key and identification while you are in the secure areas of the test center is prohibited. Exceptions to this policy may be made in certain limited circumstances. See the USMLE *Bulletin of Information* for more information.

# The United States Medical Licensing Examination (USMLE)

## Scheduling the Examination

Once ECFMG verifies that you are eligible and your registration is complete, your scheduling permit will be issued. If you apply for more than one exam at the same time, you will be issued separate scheduling permits for each exam. ECFMG will send your scheduling permit to your e-mail address of record. **You will not receive the scheduling permit or notification by postal mail.**

> **Important Note:** For Step 1 and Step 2 CK, if the beginning of your assigned eligibility period is more than six months in the future, your scheduling permit will not be available or sent via e-mail until approximately six months before the beginning of the assigned eligibility period.

**The scheduling permit is a very important document;** it includes your assigned eligibility period, a description of the form(s) of identification you must bring to the test center on your exam date, and instructions for scheduling your testing appointment. You must bring your scheduling permit to the test center on your exam date. Your name, as it appears on your scheduling permit, must exactly match the name on your form(s) of identification. The only acceptable differences are variations in capitalization; the presence of a middle name, middle initial or suffix on one document and its absence on the other; or the presence of a middle name on one and middle initial on the other. Please review your scheduling permit for additional details. **If you do not bring a copy of your scheduling permit (electronic or paper) and required identification on each day of your exam, you will not be allowed to take the exam.** If you are not allowed to take the exam, you must pay a fee to reschedule your exam. Your rescheduled testing appointment must fall within your assigned eligibility period.

If the name listed on your scheduling permit is not correct, contact ECFMG immediately. Use the contact information for General Inquiries on the Contact ECFMG page of the ECFMG website.

If your name of record with us is changed while you are registered for an exam, a revised scheduling permit reflecting this change will be issued. ECFMG will send your revised scheduling permit via e-mail. You must bring the revised scheduling permit to the test center. Name changes must be received **and processed** by ECFMG no later than seven business days before your testing appointment, or you will not be able to test. For Step 1 or Step 2 CK, if your eligibility period is extended or your testing region is changed while you are registered, a revised scheduling permit reflecting this change will be issued. You must bring the revised scheduling permit to the test center.

If you lose your scheduling permit, you can access it via our on-line services.

## Scheduling

You can schedule your testing appointment as soon as you obtain your exam scheduling permit. Please refer to your scheduling permit for instructions on reviewing available test dates and centers and scheduling a testing appointment. Test dates are provided on a first-come, first-served basis. The USMLE program cannot guarantee the availability of test centers. Therefore, you should contact Prometric to schedule as soon as possible after receiving your scheduling permit.

It is also recommended that you schedule your test dates early in your eligibility period to provide flexibility in case you need to reschedule. If you do not schedule and take the exam within your eligibility period, you must reapply by submitting a new application and exam fee(s) if you wish to take the exam.

## Rescheduling

If you are unable to keep your Step 1 or Step 2 CK testing appointment, you are permitted to change (reschedule, cancel, change test center location) your appointment within your eligibility period. Rescheduling fees may apply. A fee schedule is posted on the USMLE website ↗. Refer to your scheduling permit for details on contacting Prometric to change your appointment.

If you cannot take the Step 1 or Step 2 CK exam during your assigned eligibility period, you may request a one-time, contiguous eligibility period extension via our on-line services. Additional information and instructions are provided with the application.

If you cannot take the Step 1 or Step 2 CK exam in the testing region you selected, you may request to change your testing region. Additional information and instructions are provided with the form.

# The United States Medical Licensing Examination (USMLE)

## Preparing for Examination

For detailed information on test lengths and formats, see *The USMLE: Purpose, Format, and Lengths* in the USMLE *Bulletin of Information*. See also *USMLE Checklist: What Do I Need To Do* in the USMLE *Bulletin of Information*.

Practice materials for all Steps are available in the Prepare for Your Exam ⤢ section of the USMLE website.

The NBME offers web-based self-assessments to help medical students and graduates evaluate their readiness for Step 1, Step 2 CK, and Step 3. For complete information, see Taking an NBME Self-Assessment ⤢ on the NBME website.

Practice Sessions for USMLE Step 1, Step 2 CK, and Step 3 are available at Prometric test centers to registered applicants for a fee. These sessions are provided primarily to give examinees the opportunity to become familiar with the Prometric test center environment. For more information, see USMLE Computer-based Testing Practice Session ⤢ on the USMLE website.

> **Important Note:** Test preparation courses and materials are available from individuals and companies not associated with the USMLE. It is unlawful for any test preparation service or program to use, disclose, distribute, or solicit content from recent test takers, or to otherwise provide access to questions or answers from actual USMLE exams. If there is evidence that you enrolled in, participated in, or used any test preparation program or service that distributes, provides access to, or uses USMLE content (questions or answers), or provides a forum for others to share such information, your registration and/or testing may be canceled, your scores on the USMLE may be withheld or canceled, and you may be subject to further sanctions. See *Irregular Behavior* in the USMLE *Bulletin of Information*. ECFMG also regularly reviews allegations of irregular behavior in conjunction with its programs and services. See *Policies and Procedures Regarding Irregular Behavior*, which may apply.

# The United States Medical Licensing Examination (USMLE)

## Taking the Examination

For detailed information on arrival times, and procedures upon arrival and throughout the testing day, see *Examination Day and Testing* in the USMLE *Bulletin of Information*. You should also refer to your scheduling permit for important information.

> **Important Note:** Once you enter your candidate identification number (CIN) and launch the examination, you cannot cancel or reschedule that examination. If you start the examination but do not complete it, the attempt may appear as "incomplete" on your USMLE transcript.

When you arrive at the test center, you must present your **scheduling permit** and the **required identification** as described on your scheduling permit. **If you do not bring a copy of your scheduling permit (electronic or paper) and required identification on each day of your exam, you will not be admitted to the test** and will be required to pay a fee to reschedule your test.

Your name, as it appears on your scheduling permit, must match the name on your form(s) of identification exactly. The only acceptable differences are variations in capitalization; the presence of a middle name, middle initial or suffix on one document and its absence on the other; or the presence of a middle name on one and middle initial on the other. Please review your scheduling permit for additional details. If the name listed on your scheduling permit is not correct, contact ECFMG immediately. Use the contact information for General Inquiries on the Contact ECFMG page of the ECFMG website.

If your name of record is changed while you are registered for an exam, a revised scheduling permit reflecting this change will be issued. ECFMG will send your revised scheduling permit via e-mail. You must bring this revised scheduling permit to the test center. Name changes must be received **and processed** by ECFMG no later than seven business days before your testing appointment, or you will not be able to test. For Step 1 or Step 2 CK, if your eligibility period is extended or your testing region is changed while you are registered, a revised scheduling permit reflecting this change will be issued. You must bring the revised scheduling permit to the test center.

## Required Identification

Your name, as it appears on your scheduling permit, must exactly match the name on your form(s) of identification. The only acceptable differences are variations in capitalization; the presence of a middle name, middle initial or suffix on one document and its absence on the other; or the presence of a middle name on one and middle initial on the other. Please review your scheduling permit for additional details. Since your name on the scheduling permit appears in the Latin alphabet (in "English language letters"),

the name on your identification must also appear in the Latin alphabet. The spelling of the name on your scheduling permit must match **exactly** the spelling of the name on the form(s) of identification you present at the test center. If the names do not match as described above, you will not be allowed to take the exam. See *Your Name* in *Your Record*.

The form of identification you present must be one of the forms of **unexpired**, government-issued identification listed below that contains your **name in the Latin alphabet**, your **signature**, and your recent **photograph.** The following forms of identification are acceptable, only if they meet all of these requirements:

- Passport
- Driver's license with photograph
- National identity card
- Other form of unexpired, government-issued identification

## Travel Status

Applicants traveling to the United States to take an exam are responsible for making the necessary travel and accommodation arrangements. If you are neither a U.S. citizen nor a U.S. lawful permanent resident, you are responsible for obtaining required travel documents. These documents may include a visa to enter the United States. The requirements of the U.S. Department of Homeland Security (DHS) and U.S. embassies and consulates regarding issuance of visas and travel to and from the United States are subject to change. You should review current requirements before applying for a visa. For additional information, visit the DHS website ☑ and the U.S. Department of State website ☑.

# The United States Medical Licensing Examination (USMLE)

## USMLE Program and Irregular Behavior

The USMLE program defines irregular behavior as including, "any action by applicants, examinees, potential applicants, or others that could compromise the validity, integrity, or security of the USMLE process." Test center staff monitor, in person and via video/audio recording, administration of the USMLE Steps and are required to report any violations of the USMLE or test center rules. You must follow instructions from test center staff throughout the examinations; failure to do so may result in a finding that you have engaged in irregular behavior and permanent annotation of your USMLE transcript. See *Testing Regulations and Rules of Conduct* and *Irregular Behavior* in the _USMLE Bulletin of Information_. See ECFMG's _Policies and Procedures Regarding Irregular Behavior_, which also may apply.

> **Important Notes:** Seeking, providing, and/or obtaining information relating to examination content that may give or attempt to give unfair advantage to anyone who may be taking the examination, which includes postings regarding examination content and/or answers on the Internet, is a violation of the USMLE Rules of Conduct.

> Evidence of violation of any test administration rule, including the USMLE Rules of Conduct, will result in actions being taken under *USMLE Policies and Procedures Regarding Irregular Behavior*. If you are found to have engaged in irregular behavior, your score report and transcripts will include this finding, you may be barred from taking the USMLE in the future, and your score may be canceled.

> Anomalous performance and/or unusual testing history may impact your access to the USMLE. If your performance raises concerns about your readiness to test or your motivation to pass, the USMLE program reserves the right to restrict your future access to its examinations and/or to impose conditions upon future access. Do not test if you are not able or not ready on your scheduled test date. Taking a Step examination to familiarize yourself with the examination format, or for any reason other than to pass, is prohibited and may result in restrictions on your future access to the USMLE.

The above-described conduct may also be considered irregular behavior under ECFMG's _Policies and Procedures Regarding Irregular Behavior_.

# The United States Medical Licensing Examination (USMLE)

## Examination Results

The USMLE program provides a recommended pass or fail outcome on all Step examinations. For ECFMG Certification, you must obtain at least the USMLE-recommended pass outcome for each required Step. See *Examination Requirements* in *Examinations for ECFMG Certification*.

## Score Reporting

Results for Step 1 and 2 CK are typically available two to four weeks after your test date. However, a number of factors may delay score reporting. When selecting your test date and inquiring about results, you should allow at least eight weeks to receive notification that your score report is available. For more specific information about potential scoring delays, visit the Announcements section on the home page of the USMLE website ↗.

ECFMG reserves the right to reverify with the medical school the eligibility of medical school students and graduates who are registered for examination. If ECFMG requests reverification of your student/graduate status with your medical school, your score report will be issued only after reverification of your status has been received by ECFMG.

Score reports are issued in electronic format only and can be accessed via our on-line services. Once your score report has been issued, ECFMG will send a notification to your e-mail address of record.

Score reports are available for approximately 365 days from the date of e-mail notification. Once the score report is removed from our on-line services, your results will be provided to you only in the form of an official USMLE transcript; see USMLE Transcripts below. Therefore, it is strongly recommended that you print and/or save your score report while it is available.

Important Note: ECFMG may provide your medical school with data on your performance on administrations of USMLE Step 1 and Step 2. Data provided include whether you passed or failed the exam administration and your numerical score, if one was reported for your exam administration.

Information about *ECFMG's Provision of Performance Data to Medical Schools* and an option for you to withhold your exam results from your medical school are available via our on-line services.

See *Score Reporting* in the USMLE *Bulletin of Information* for additional information. For up-to-date information on minimum passing scores, examination performance data, and general scoring methodology, please visit the USMLE website ↗.

## Score Validity

The USMLE program reserves the right to cancel scores that are at or above the passing level if the USMLE program has a good faith basis for questioning whether they represent a valid measure of knowledge or competence as sampled by the examination. If there are questions related to the validity of your score, your score report may be delayed or withheld pending completion of further review and/or investigation. See *Score Validity* in the USMLE *Bulletin of Information*.

## USMLE Transcripts

To request an official USMLE transcript, you must contact the organization that registered you for the examination. You must contact the Federation of State Medical Boards (FSMB) if you are registered for or have taken Step 3 and/or you want to send your transcript to a U.S. medical licensing authority. In all other cases, you can submit your request for an official USMLE transcript to ECFMG. Additional information and instructions are provided with the form.

If you apply to residency programs through the Electronic Residency Application Service (ERAS), you may request electronic transmittal of your USMLE transcript to these programs. For additional information, refer to the ERAS Support Services section of the ECFMG website.

> **Important Note:** If you took the former ECFMG CSA, your USMLE transcript will indicate only that you have CSA examination history. It will not provide any additional information on your attempt(s) on the CSA. To request official copies of your CSA performance history, you must submit your request for an official CSA history chart to ECFMG with the appropriate fee. Additional information and instructions are provided with the form.

## Score Rechecks

For all Steps, a highly rigorous process is used to ensure the accuracy of scores, including a parallel scoring method involving independent scoring systems. Therefore, a change in your score or in your pass/fail outcome based on a recheck is an extremely remote possibility. To date, the score recheck process has not resulted in a score change. However, a recheck will be performed if you submit a request and the fee for this service to the organization that registered you for your examination. For Step 1/Step 2 CK, additional information and instructions are provided with the form. Your request must be received no later than 90 days after your result was released to you. See *Score Rechecks* in the USMLE *Bulletin of Information* for more information.

# The United States Medical Licensing Examination (USMLE)

## Reexamination and Reapplication

USMLE policy generally does not allow applicants to retake a Step if they have already passed that Step. However, there are exceptions for the purpose of complying with a time limit imposed by a U.S. physician licensing authority or another authority recognized by the USMLE program. See *Time Limit for Completing Examination Requirements* below.

If you fail a Step, you must reapply, including payment of the appropriate fee(s), to retake the exam. If you do not take an exam during your assigned eligibility period, you must reapply, including payment of the appropriate fee(s), if you wish to take the exam; **in this event, you may reapply at any time, however, ECFMG cannot begin to process a subsequent application for this exam until at least four weeks after the end of the eligibility period for the exam you did not take.**

## Number of Attempts Allowed

The USMLE program limits to four the total number of times an examinee can take the same Step. Examinees who have attempted a Step four or more times, including incomplete attempts, and have not passed are ineligible to apply for **any** Step in the USMLE exam sequence. Attempts at the formerly administered Step 2 CS count toward the limit. All attempts at a Step are counted toward the limit, regardless of when the exams were taken.

For the purpose of U.S. medical licensure, state medical licensing authorities may limit the number of attempts allowed to pass each Step. Information regarding specific state requirements can be obtained on the Federation of State Medical Boards (FSMB) website ↗.

## Time Between Examination Attempts

The USMLE program has established rules on how quickly you can retake the same Step. You may not take the same examination more than three times within a 12-month period. Your fourth attempt must be at least 12 months after your first attempt at that exam **and** at least six months after your most recent attempt at that exam. This includes incomplete attempts.

> **Example:** An examinee took and failed her first attempt at Step 1 on January 15, 2021, her second attempt at Step 1 on April 15, 2021, and her third attempt at Step 1 on September 15, 2021. In January 2022, the examinee applied for a fourth attempt at Step 1 and wanted the March-April-May eligibility period. The earliest date that was both 12 months after her first attempt on January 15, 2021 and six months after her most recent attempt on September 15, 2021 was March 15,

2022. Since the March- April-May eligibility period began before this date, the earliest eligibility period that the applicant could request was April-May-June.

When you reapply, your eligibility period will be adjusted, if necessary, to comply with these rules. You must read the editions of the ECFMG *Information Booklet* and the USMLE *Bulletin of Information* that pertain to the eligibility period in which you take the exam.

## Time Limit for Completing Examination Requirements

For the purpose of ECFMG Certification, you must satisfy the examination requirements for ECFMG Certification within a seven-year period. If you do not satisfy the examination requirements for ECFMG Certification within a maximum of seven years, your earliest USMLE passing performance will no longer be valid for ECFMG Certification. See *Time Limit for Completing Examination Requirements* in *Examinations for ECFMG Certification*.

If you have passed a Step but this passing performance is no longer valid for ECFMG Certification, you may request an exception to retake the previously passed exam that is no longer valid. The USMLE program's policy on attempt limits may impact an applicant's ability to retake the examination that is no longer valid.

For the purpose of U.S. medical licensure, time limits to complete the USMLE are established by state medical licensing authorities and may require completion of all Steps (including Step 3, which is not required for ECFMG Certification) within a certain number of years from the date the first Step is passed. Information regarding specific state requirements can be obtained on the FSMB website ☒. You may request an exception to retake a previously passed exam to comply with the time limit of a U.S. physician licensing authority. Visit the USMLE website ☒ for more information.

> **Important Notes:** You may only request an exception at the time that you apply for the previously passed exam. Complete requirements and instructions will be provided at the time of exam application. Exceptions to the reexamination requirements are not approved prior to your submitting the exam application.

> Applicants who retake a previously passed Step to comply with a time limit should understand the implications of a failing retake performance on their Step 3 eligibility. See *Retaking Previously Passed Steps* in the USMLE *Bulletin of Information*.

## Medical Education Credentials

### Medical Education Credential Requirements

To be eligible for ECFMG Certification, you must have been awarded credit for at least four credit years (academic years for which credit has been given toward completion of the medical curriculum) by a medical school that is listed in the *World Directory* with an ECFMG note stating it meets ECFMG eligibility requirements. Your graduation year must be included in the ECFMG note in your medical school's *World Directory* listing. See *Medical School Requirements*. There are restrictions on credits transferred to the medical school that awards your medical degree that can be used to meet ECFMG's medical education credential requirements.

> **Important Notes:** Graduates not eligible for admission to the exams or for ECFMG Certification include, but are not limited to: Graduates with degrees only in stomatology, ayurvedic or homeopathic medicine; graduates awarded only the diploma of Physician-Epidemiologist-Hygienist, Physician-Biochemist, Physician-Cyberneticist, Physician-Biophysicist, Licensed Medical Practitioner, or Assistant Medical Practitioner; and graduates awarded degrees in specialties other than Clinical Medicine (such as in Traditional Chinese Medicine).

> Starting in 2024, ECFMG will begin implementation of the ECFMG Recognized Accreditation Policy. The policy links ECFMG Certification to the accreditation status of a medical school. For the latest information on the forthcoming policy, please monitor the ECFMG website at www.ecfmg.org/accreditation.

International medical graduates must document the completion of all requirements for, and receipt of, the **final medical diploma.** ECFMG verifies every international medical graduate's final medical diploma with the appropriate officials of the medical school that issued the diploma. When ECFMG requests verification of your medical diploma from your medical school, ECFMG will request the medical school to provide your **final medical school transcript.** Verification by ECFMG with the issuing school may also be required for transcripts that are submitted to document transferred credits. An international medical graduate's credentials are not considered complete until ECFMG receives and accepts verification of the final medical diploma, final medical school transcript, and, if required, transfer credit transcript(s) directly from the issuing school(s).

Please do not send original documents, as they will not be returned to you. Please do not send any credentials not required (such as licenses, certificates of full registration, high school diplomas, academic awards, etc.). Submission of unnecessary documents can delay the processing of your exam application.

## Medical Education Credentials

### ECFMG Policy on Transfer Credits

Transfer credits are credits earned for a course taken at one institution (such as a medical school) that are accepted by a medical school toward meeting its degree requirements. For example, a student attends a medical school for one year and earns credits for 12 courses. The student transfers to another medical school, which accepts the credits for those 12 courses toward meeting its degree requirements. The credits for those 12 courses are then referred to as transfer credits.

If you transferred credits to the medical school that awarded or will award your medical degree, you must disclose and document these credits when you apply to ECFMG for examination, **regardless of when the credits were earned.** See *Credentials for ECFMG Certification* in *Medical Education Credentials*. Failure to disclose and document these credits may have a number of negative consequences, including delaying exam registration and certification by ECFMG, and may result in a finding of irregular behavior and permanent annotation of your record. See *Policies and Procedures Regarding Irregular Behavior*.

Additionally, for the purpose of ECFMG Certification, credits that are transferred to the medical school that awarded or will award your medical degree must meet **all** of the following criteria:

- All credits must have been transferred from a medical school that is either:
    - located in the United States or Canada and listed in the *World Directory*, or
    - listed in the *World Directory* with an ECFMG note stating it meets ECFMG eligibility requirements.
- Credits must be for courses that were passed at the medical school at which the course was taken.
- Credits may only be transferred from **one** medical school to the medical school which awards the final degree.

If your transferred credits do not comply with all the criteria listed above, you will not meet the requirements to be registered by ECFMG for examination or the requirements to be certified by ECFMG. If your transferred credits do not meet **all** the criteria listed above, you may request an exception from the ECFMG Medical Education Credentials Committee.

> **Important Note:** The requirement that credits must be transferred from a medical school that meets the criteria above does not apply to credits transferred **only to the pre-medical portion of the curriculum** of the medical school that awarded or will award the medical degree. If you transferred credits to the pre-medical portion of the curriculum at the medical school that awarded or will award your medical degree from an institution that does not meet the criteria listed above,

you must provide ECFMG with a letter from the medical school that awarded or will award your medical degree confirming that the credits were transferred to the pre-medical portion of the curriculum only. This letter must be on the letterhead of the medical school and be signed by an authorized official of your medical school. This letter must be submitted in conjunction with the application for examination. Applications received without this letter may be rejected. **This letter is in addition to disclosing and documenting all transferred credits as described above.**

The intent of this policy on transfer credits is to preserve the appropriate education of medical school graduates applying to ECFMG for Certification. The provisions of this policy will be applied by ECFMG in its sole discretion in order to effectuate the intent of this policy.

**Important Note:** Transfer credits that ECFMG reviewed and deemed to have met requirements for ECFMG Certification prior to August 27, 2019, will remain acceptable, and these applicants will be allowed to proceed with Certification and the examinations leading to Certification. All future transfer activity will be subject to the policy as stated here.

## Medical Education Credentials

### Credentials for ECFMG Certification

The credentials required for ECFMG Certification are:

- *Final Medical Diploma*
- *Final Medical School Transcript*
- *Transcript(s) to Document Transferred Credits*, if applicable

All documents that are not in English must be accompanied by an official English translation that meets ECFMG's translation requirements. See *Final Medical Diploma and Transcript*, *Transcript(s) to Document Transferred Credits*, and *English Translations* for complete information on required items.

**If you are a medical school graduate** when you submit your first exam application, your **diploma** and **transcript(s) to document transferred credits** (if applicable) must be submitted at the same time as this initial exam application. If you have graduated and met all requirements for your medical diploma but your medical diploma has not yet been issued, a letter completed and signed by an authorized official of your medical school must be submitted at the same time as your exam application. Each medical school has been requested to provide ECFMG with a list of authorized officials. The letter you submit must be completed and signed by an official on this list. The official must provide his/her name, official title, and the institution name. The official must affix the institution's seal to the letter. The letter also must include the following statement:

> This is to confirm that [applicant name] has graduated and completed all requirements to receive the [degree title] degree from [medical school/university name]. The degree will be issued [month and year].

You must then submit a copy of your diploma to ECFMG as soon as the diploma is issued.

**If you graduated from medical school and do not submit a copy of your medical diploma or a letter from your medical school, as described above, within four weeks of submitting the on-line portion of your exam application, and these documents have not been received previously by ECFMG, your exam application will be rejected.**

**If you are a medical school student** when you submit your first exam application, submit copies of your medical education credentials as soon as you graduate and receive them.

You may not submit the credentials required for ECFMG Certification to ECFMG until you apply for an exam. If you send credentials to ECFMG before you apply for an exam, they will not be processed.

You can submit your credentials via our on-line services. Additional information and instructions are provided with the exam application. If your credentials are complete, you are generally not required to resend these documents when you apply for subsequent exams.

When your credentials have been processed, ECFMG will notify you. You can also check the status of your credentials via our on-line services. If you have questions or concerns about your credentials, you can contact ECFMG using the contact information for General Inquiries on the Contact ECFMG page of the ECFMG website.

## Medical Education Credentials

### Final Medical Diploma and Transcript

#### Final Medical Diploma

ECFMG requires all medical school graduates to submit a copy of their final medical diploma to ECFMG. Do not send an original diploma. You can submit your credentials via our on-line services. Additional information and instructions are provided with the exam application.

The exact degree title of the final medical diploma you must have earned (and must provide) in order to be eligible for ECFMG Certification and the examinations required for Certification is listed in the *Reference Guide for Medical Education Credentials* on the ECFMG website. The *Reference Guide* lists these medical credential qualifications by medical school and graduation year. Although this *Reference Guide* is based upon information that was current at the time of publication, this information is subject to change.

You must submit the copy of the final medical diploma in the original language, containing the issue date and all of the appropriate signatures of the medical school and/or university officials. Documents that are not in English must be accompanied by an official English translation that meets ECFMG's translation requirements. See *English Translations* in *Medical Education Credentials*.

Do not submit professional evaluations of your final medical diploma. ECFMG does not accept such evaluations in lieu of your final medical diploma.

If you are submitting the copy of your medical diploma with an exam application, follow the instructions for additional documents in the exam application. The name on your medical diploma should match **exactly** the name in your record. If the name on your diploma does not match your name of record, you must submit documentation that **verifies** the name on your diploma is (or was) your name. See *Name on Medical Diploma and Transcript(s)* in *Medical Education Credentials*.

#### Final Medical School Transcript

When ECFMG requests verification of your medical diploma from your medical school, ECFMG will request the medical school to provide your final medical school transcript. If ECFMG is unable to obtain your final medical school transcript directly from your medical school, ECFMG will contact you and provide detailed instructions.

**Medical Education Credentials**

## Transcript(s) to Document Transferred Credits

If you have transferred credits to the medical school that awarded or will award your medical degree, you must document these credits when you apply for examination, regardless of when the credits were earned. You must send to ECFMG a copy of an official transcript issued by the school or institution at which the course was taken. You can submit your credentials via our on-line services. Additional information and instructions are provided with the exam application.

You must submit the copy of the transcript in the original language. Documents that are not in English must be accompanied by an official English translation that meets ECFMG's translation requirements. See *English Translations* in *Medical Education Credentials*.

Do not submit professional evaluations of your transcript. ECFMG does not accept such evaluations in lieu of your transcript.

To submit the transcript to ECFMG, follow the instructions for additional documents in the exam application.

The name on your transcript(s) to document transferred credits should match **exactly** the name in your record. If the name on your transcript does not match your name of record, you must submit documentation that **verifies** the name on your transcript is (or was) your name. See *Name on Medical Diploma and Transcript(s)* in *Medical Education Credentials*.

## Medical Education Credentials

### Name on Medical Diploma and Transcript(s)

Your name as it appears on **all** credentials sent to ECFMG should be consistent and should match **exactly** the name in your record. If the names do not match exactly, you must submit documentation that **verifies** the name on your medical diploma/transcript(s) is (or was) your name. The documentation must show your name exactly as it appears on your medical diploma/transcript(s). See *Your Name* in *Your Record* and *Verifying Your Name*.

**If the name on your credentials does not match the name in your record and you do not submit acceptable documentation that verifies the name on your credentials is (or was) your name, your exam application will be rejected. If your exam application is rejected due to a name discrepancy, ECFMG will contact you to request additional information.**

An example of a discrepancy that requires such verification would be if your record lists your married name, but your medical diploma/transcript(s) lists your maiden name.

### Verifying Your Name

If your name of record does not match **exactly** your name as listed on your medical diploma, transcript, or other credential, you must **verify** that the name on these documents is (or was) your name. To verify your name, submit to ECFMG a copy of one of the documents listed below that verifies the name on your medical diploma, transcript, or other credential. The name in your record will not be changed if you are verifying your name.

For the purpose of verifying your name, examples of the document(s) you may submit include:

- Expired Passport (including the pages with your photograph and the expiration date)
- Birth Certificate
- Marriage Certificate/License (if name discrepancy is due to name change after marriage)
- Official Court Order/Name Change Documentation
- Official Immigration Document, including
  - U.S. Resident Alien Card
  - U.S. Naturalization Certificate
  - Permanent Residence Card
- Driver's License

If additional documentation is required for the purposes of verifying your name, and you cannot provide one of the documents listed above, ECFMG will consider accepting a letter from an authorized official of your medical school that verifies that the name on your medical diploma, transcript, or other credential is (or was) your name. If you choose to submit a letter from your medical school to verify the name on your credential, the letter must be completed and signed by an authorized official of your medical school. Each medical school has been requested to provide ECFMG with a list of authorized officials. The letter you submit must be completed and signed by an official on this list. The official must provide his/her name, official title, and the institution name. The official must also affix the institution's seal to the letter. The letter must be on letterhead and must include the following statement:

> **This certifies that the names [name on document] and [name in ECFMG record] belong to one and the same person.**

See additional important information on documents below.

## Important Information on Documents for Changing or Verifying Your Name

- Attestations are **not** acceptable as documentation to change or verify your name.
- Please do not submit an original document; a copy of the document is sufficient.
- All documents submitted to change or verify your name that are not in English must be accompanied by an official English translation that meets ECFMG's translation requirements. See *English Translations* in *Medical Education Credentials*.
- All documents submitted to change or verify your name, including translations, will become a part of your permanent record and will not be returned to you.

## Medical Education Credentials

### English Translations

Any document submitted to ECFMG that is not in English must be accompanied by an English translation that meets ECFMG's translation requirements.

**ECFMG strongly encourages you to obtain translations from its recommended translation service.** Translations from this service meet ECFMG's requirements and will not be rejected for not meeting these requirements. See the [Translation Service](#) page in the Resources section of the ECFMG website.

Translations from other services may not meet ECFMG's requirements. All translations must:

- be a word-for-word translation of the original language document. An abstract or summary translation of the document is not acceptable.
- be prepared from the original document or a photocopy of the original document. ECFMG will not accept a translation prepared from a transcription (transcribed version) of the document.
- be prepared by a government official (for example, a Consular Officer), medical school official (for example, a Dean or Registrar), or a professional translation service.
- bear the signature and title of the government or medical school official or representative of the translation service and, if there is one, the seal of the government official, medical school, or translation service.
- appear on letterhead. If the translation service is a private company, the letterhead must identify the company as a translation service.
- **include a certification statement from the translator stating the following: I [insert name of translator] certify that the word-for-word translation is correct.**

An English language certificate issued by the medical school that is not a word-for-word English language version of the degree, transcript, or other document in the original language is not acceptable as a translation. English translations that do not meet the requirements above will not be accepted. Examples of unacceptable translations include, but are not limited to:

- translations prepared by a notary who is not a government or medical school official or representative of a professional translation service,
- a translation that was not signed by the translator or official or representative of the translation service,
- a translation that is not a word-for-word translation of the original language document, and
- a translation that does not contain the certification statement from the translator.

Additionally, applicants are not permitted to translate their own documents.

Documents submitted to ECFMG as part of the exam application and certification processes, including translations, will not be returned.

> **Important Note:** If the credential provided by your medical school is not in English and an acceptable English translation is not provided by the medical school, ECFMG will have the credential translated into English by an independent translation service. ECFMG will charge your financial account for the translation and will subsequently notify you of the charge. ECFMG will not notify you before sending the document for translation. For information on the translation fee and how to make a payment to your financial account, see Fees and Payment in the Resources section of the ECFMG website.

## Medical Education Credentials

## Verification of Credentials

ECFMG verifies every international medical graduate's final medical diploma with the appropriate officials of the medical school that issued the diploma. At the same time, ECFMG requests the medical school to provide the final medical school transcript. Transcripts to document transferred credits are also subject to verification by ECFMG with the issuing school. You will not fulfill the ECFMG medical education credential requirements until verification of your final medical diploma, final medical school transcript, and, if required, transfer credit transcript(s) is received directly from the issuing school(s) and accepted by ECFMG.

ECFMG will notify you when your diploma has been sent to your medical school for verification. As part of the verification process, ECFMG also may provide the medical school with other documents, including a copy of your identification form to aid in identification. ECFMG will follow up with your medical school if the requested verification is not received in a timely manner. ECFMG will notify you after receiving and evaluating the verification from your medical school. You can check the status of your medical education credentials on-line via our on-line services.

ECFMG reserves the right to reverify with the medical school the eligibility of medical school graduates who apply for examination. This may include reverification of the graduate's medical education credentials with the issuing medical school. If such reverification is requested, the graduate will be registered for examination only after ECFMG has received reverification directly from the medical school. If reverification is requested after the graduate has been registered for examination, ECFMG may cancel the graduate's registration or withhold the graduate's score report until ECFMG has received reverification directly from the issuing school. If your registration is canceled, you may be required to reapply.

> **Important Notes:** Applicants are responsible for any fees associated with the verification of the final medical diploma, final medical school transcript, and transcript(s) to document transferred credits. If your medical school charges a fee for the verification of your diploma and/or transcript, ECFMG will advise you to contact your medical school directly regarding the fee and the method of payment.

> If the final medical school transcript provided by your medical school is not in English and an acceptable English translation is not provided by the medical school, ECFMG will have the transcript translated into English by an independent translation service. ECFMG will charge your financial account for the translation, and will subsequently notify you of the charge. ECFMG will not notify you before sending the document for translation. For information on the translation fee and how to make a payment to your financial account, see Fees and Payment in the Resources section of the ECFMG website.

## Appendix

### Related ECFMG Services

#### Confirming ECFMG Certification to Third Parties

ECFMG's Certification Verification Service (CVS) provides primary-source confirmation of the ECFMG certification status of international medical graduates. The Joint Commission, the organization that evaluates and accredits U.S. health care organizations and programs, has determined that direct verification with ECFMG of a physician's certification status satisfies The Joint Commission's requirement for primary-source verification of medical school completion for graduates of international medical schools. ECFMG will confirm your certification status when a request is received from a U.S. medical licensing authority, residency program, hospital, or other organization that, in the judgment of ECFMG, has a legitimate interest in such information. For status reports sent to medical licensing authorities, the request can also be made by you. Requesting organizations must normally secure and retain your signed authorization to obtain certification information.

For more information, visit www.ecfmg.org/cvs.

#### Electronic Residency Application Service (ERAS®) Support Services

The Association of American Medical Colleges (AAMC) established the Electronic Residency Application Service (ERAS) to allow medical students and graduates to apply electronically for residency positions in accredited U.S. programs of graduate medical education. Most U.S. graduate medical education programs participate in ERAS. If you apply to participating programs, you must submit your residency application using ERAS.

ECFMG serves as the designated Dean's office for students and graduates of international medical schools, assisting these individuals with the ERAS application process for first- and second-year (PGY-1 and PGY-2) residency positions.

For detailed, up-to-date information on ERAS Support Services at ECFMG, visit www.ecfmg.org/eras.

#### J-1 Visa Sponsorship

Foreign national physicians who seek entry into U.S. programs of graduate medical education or training must obtain an appropriate visa that permits clinical training activities. One visa commonly used by foreign national physicians is the J-1, a temporary nonimmigrant visa reserved for participants in the Exchange Visitor Program. As a public diplomacy initiative of the U.S. Department of State, the Exchange

Visitor Program was established to enhance international educational and cultural exchange between the people of the United States and other nations.

The U.S. Department of State has designated ECFMG as the visa sponsor for all exchange visitor (J-1) physicians who participate in clinical training programs. ECFMG sponsorship is also available for physicians' eligible dependents. ECFMG does not sponsor physicians for other U.S. visa types.

For detailed, up-to-date information on J-1 visa sponsorship by ECFMG, visit www.ecfmg.org/evsp.

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REPORT

# GME Track

GME Track® is a resident database and tracking system that was introduced in March 2000 to assist GME administrators and program directors in the collection and management of GME data. GME Track contains the National GME Census, which is jointly conducted by the Association of American Medical Colleges and the American Medical Association and reduces duplicative reporting by replacing the AAMC's and AMA's previously separate GME surveys. The National GME Census is completed by residency program directors and institutional officials. The Census is comprised of two components: the Resident Survey and the Program Survey. Resident data and program data are confirmed annually, and the survey cycle can be updated between May and February, while the GME Track application is open.

**Data Contacts**

Contact GME Track Help

✉ gmetrack@aamc.org

📞 202-862-6171

Request AAMC Data

✉ datarequest@aamc.org

## Benefits of GME Track include:

- Immediate and on-going access to biographical and training information

- Ability to view and print resident information and program rosters

- Medical schools have access to GME Track, with the ability to view and download their graduates' GME data

- In addition, GME Track data are used by both organizations, in accordance with each organization's privacy and data use policies, to provide medical students, residents, and the academic medicine community with information about specific programs through online search tools (e.g., FREIDA™, the AMA Residency & Fellowship Database®; and AAMC's Residency Explorer). Furthermore, GME Track data are used for research and educational purposes to inform policy analyses, to conduct research studies and outcomes evaluations, and to provide data reports and ad hoc data requests to qualified third parties.

AMA

Member Benefits | Join | Renew | 👤 Sign In ▼

FREIDA™

Search Programs    Explore Specialties    Tools & Resources ▼    Program Director Portal    Dashboard 🔖

## Contact FREIDA

# Frequently Asked Questions

### Already an AMA member but can't access the FREIDA Dashboard?
• To check if your membership is in good standing, go to amc.ama-assn.org
• If you are a member, but your membership type is non-physician, click the link to upgrade your account
• Update your online account to Physician, Resident, or Medical Student and log out of all AMA pages
• Go to FREIDA.ama-assn.org and log back in to use your AMA member dashboard

### Where does FREIDA Online data come from?
Program data on FREIDA Online come directly from the programs themselves via the GME Track/National GME Census (www.aamc.org/gmetrack), an annual online survey jointly conducted by the American Medical Association and the Association of American Medical Colleges. Data are loaded onto FREIDA in mid-August for those programs that complete the National GME Census by the mid-July due date, again in October (for data received by the end of September), and a final upload in February. Information on GME participating hospital institutions is provided by Health Forum, LLC, an affiliate of the American Hospital Association.

### Can anyone search for residency/fellowship programs on FREIDA?
Yes, anyone can use FREIDA Online. However, users of FREIDA Online must have an AMA account to search for programs. With an AMA account, you can access other AMA resources, register for educational opportunities, and subscribe to AMA email newsletters. Creating an account does not mean you are becoming an AMA member. AMA members do, however, have additional FREIDA Online benefits, such as saving searches into a Comparison List and creating a Dashboard to store personal observations about your residency program research. You can learn more about AMA membership here.

### Do AMA members have additional FREIDA Online benefits?
Yes, AMA members are able to save program searches into the Comparison List and into the Dashboard, and can utilize the Dashboard to help organize their search for programs of interest.

### How do I save results of a program search on FREIDA Online?
AMA members can save results of a search into the Comparison List or into the Dashboard. Select the program you're interested in, either from the Search results or from a program's page on FREIDA Online, and select Add to Comparison or Add to Dashboard. You can also add programs to the Dashboard from the Comparison table.
If you are not an AMA member, you can add programs to the Comparison List only during the current browser session.

### How can I find programs that... ?
Use the Keywords box to type in terms to narrow your search. Keywords Search provides tips and terms to use.

### Why is there more information for some programs than others?
Basic information is provided for all ACGME-accredited programs and Board-approved combined programs. In addition, most programs choose to provide even more information about their programs by "leasing" supplemental space on FREIDA. Some programs do not choose this option.

### Can I bookmark FREIDA Online for future use?

The bookmark for FREIDA Online can be found here. You can also bookmark a program's listing, but keep in mind that changes are made often to FREIDA Online, and you may want to refresh a bookmarked page to make sure that the information is current.

### Why can't I find listings for a particular specialty?

FREIDA Online contains listings for 2 types of programs: (1) programs in specialties that have Accreditation Council for Graduate Medical Education (ACGME) program requirements, and (2) combined programs that are jointly approved by two or more applicable certification boards (e.g., internal medicine/psychiatry).
If you cannot find listings for a particular specialty or combined program (for example, cutaneous oncology), check with the relevant specialty society for more information about these non-ACGME accredited specialties.

### Can I search for vacant residency and fellowship positions?

Yes! Click on the Vacant Positions Search link on the right navigation bar. Program directors can post positions that have become vacant during the year, or are left unfilled after the match. Users can search by specialty, state and program year level. These listings were formerly posted by the AMA Resident and Fellow Section but they are now fully integrated into FREIDA Online. You may also want to check with the specialty society of the area in which you are seeking a position. In addition, there is a service offered by FindAResident, a site sponsored by the AAMC.

### How can programs change their data after information has been uploaded from the annual survey?

Program personnel can make changes to the basic program information by clicking on Resources for Program Directors. If changes need to be made to detailed program information, they can be e-mailed to freida@ama-assn.org. Please include your 10-digit program ID number.

### I have questions about the GME Track/National GME Census. Whom do I contact?

Contact the Census Support Hotline at (800) 866-6793 or e-mail gmesurvey@ama-assn.org.

### How can I find out about the accreditation status of a program?

All programs on FREIDA Online are currently ACGME-accredited, or are combined programs that are approved by their respective specialty boards. The most recent information on the accreditation status of ACGME-accredited programs, including program review dates by residency review committees, is located on the ACGME's Web site.

### Our ACGME-accredited residency program is not listed in FREIDA Online. Why not?

If your program was newly accredited within the past several months, it is possible you missed the cutoff date. Notify FREIDA by e-mail (freida@ama-assn.org) with your 10-digit program ID number and basic information, and we will look into the issue.

# FREIDA™, the AMA Residency & Fellowship Database®

# Glossary for Program Information

### Accepting applications for training that begins____- ___

Information is provided about applications to the program for the next academic year, and for the academic year following. Academic years typically start in the summer and last for 12 months.

### Accredited length

The number of years of training the program is accredited to offer by the Accreditation Council for Graduate Medical Education (ACGME).

### Additional training or educational experiences

These include required additional training beyond the accredited length of the program, as well as additional experiences that the program offers, but are not required for completion of the program.

### Affiliated with US government

Programs that are sponsored by or affiliated with federal agencies, i.e., Air Force, Army, Navy, Public Health Service, or sponsored by the VA.

### Application dates

The deadline for applications for the next academic year, and the earliest date for which applications will be accepted by the program for the following year, as well as the deadline date.

### Average Step 1 or Level 1 scores (range)

Programs can provide within a range the average scores of the current residents/fellows.

### Average hours per week on duty

The average hours worked during the first program year.

### Beeper call

Beeper or at-home call is on-call time spent away from the institution. Some residents and fellows only have beeper call.

### Characteristics of trainees

If resident data are made available by the program, percentages of residents who are female, male, USMD, DO and IMG are provided, averaged over 3 years of data.

### COMLEX Level 1 and 2

COMLEX Level 1 and 2 scores may be required for interview consideration of DO applicants (graduates of osteopathic medical schools). Some programs post the minimum score they will accept. Some programs may require DO applicants to take the USMLE Step 1 and 2 instead of the COMLEX.

### Community-based program

The majority of experience is in a community setting that is not in an academic medical center, or a hospital with a medical school affiliation.

### Community-based university affiliated program

The majority of experience is in a community-based hospital that is affiliated with an academic medical center, but is not a primary affiliate of the academic medical center.

### Dashboard

Feature available to AMA members that allows users to save programs and add content to programs of interest.

### ERAS

Electronic Residency Application Service, by which medical students apply to residency programs through their medical schools; graduates of international medical schools apply through the ECFMG. See www.aamc.org/eras, and www.ecfmg.org/eras.

### GME

Graduate medical education, or medical education training taking place after graduation from medical school.

### Graduate year

The year of training in accredited graduate medical education, which may or may not correspond with program year. A resident in the first year of training after medical school is a GY1 resident. For example, if a resident has completed training in Internal Medicine, and now is in the first year of a Nephrology programs, the resident would be in his/her 4th Graduate Year, and 1st Program Year.

### Hospitalist track

Track or fellowship that provides special training for a career devoted largely to inpatient care.

### Visa status

Some programs do not wish to manage visa issues, and are only interested in applicants that have US citizenship or permanent residency. Other programs and institutions are able to accommodate residents on visas. It is always recommended to contact the program for clarification.

### Institution

Residency and subspecialty programs must be sponsored by an institution. The sponsoring institution assumes the ultimate responsibility for the program and is accredited by the Accreditation Council for Graduate Medical Education. A participating institution is an institution in which residents rotate for a required experience.

## Interview via video conferencing

Some programs may interview applicants remotely.

## Last updated

The date for which all or part of the information appearing for the program was last loaded onto FREIDA.

## Maximum consecutive hours on duty

The maximum number of consecutive hours a resident/fellow is allowed to be on duty by the program during the first program year.

## Military-based program

The majority of experience takes place in Army, Air Force, Navy, and Uniformed Services institutions.

## Moonlighting allowed

Moonlighting is allowed by the program, beyond GY1.

## Most taxing call schedule and frequency

This is the call schedule that places the resident/fellow in the hospital the most nights for the year. This particular schedule may be maintained for a short period of time, or could be for the entire year. Night float is not part of this call schedule.

## My notes

Part of the Dashboard – in the My Notes section, users have several opportunities to add personal content to programs of interest, such as: ratings of programs based on research or personal observation, like cultural/personality fit, faculty teaching availability, community type; completing items regarding applying, being offered an interview, interview dates; rating a program overall; intentions to rank a program; and adding comments.

## National Resident Matching Program

The NRMP matches medical students and residency programs to optimize the rank ordered choices of students and program directors. The NRMP also conducts matches for fellowship positions in more than 60 subspecialties, through its Specialties Matching Services. See www.nrmp.org.

## Night float system

A rotation where residents only work during the nights (eg, 10pm-8am), with minimal or no daytime duties.

### OSCEs

Objective Structured Clinical Examinations (OSCEs) are patient or computer simulations that are used to provide standardized assessments of residents' clinical skills.

### Osteopathic Recognition and/or is accredited by the ACGME and the AOA

The program has received Osteopathic Recognition from the ACGME, or is a program formerly accredited by the American Osteopathic Association and is now ACGME-accredited.

### Other matching program

Programs using another matching program are primarily using the military match, the urological match or the Match for osteopathic programs.

### Other program setting

The majority of experience takes place in settings that are not university, community, or military based, such as in foundations, blood banks, research institutions, cancer centers, or private practices.

### Participant institution

See Institution.

### Part-time/shared positions

Some programs will allow two residents to "share" one position in the program, or allow the resident to progress through the program at a slower pace, or part-time.

### Portfolio system

A portfolio is a collection of selected resident/fellow work packaged and organized for easy review and evaluation.

### Preliminary positions

Positions for residents who are obtaining training required to enter another program or specialty. Preliminary positions are usually 1 year in length, and usually offered for Graduate Year 1. Internal medicine, surgery, and transitional year programs commonly offer preliminary positions.

### Primary care track

Track or separate path solely devoted to primary care medicine.

### Primary teaching site

The site that provides the single largest amount of clinical experience for the program.

### Program details

Part of the Dashboard – users can add several items from each saved program's detailed

listing for comparisons between programs.

### Program faculty

Provides a breakdown of physician, non-physician, full-time and part-time faculty, the percent full-time female physician faculty, and a ratio of faculty to number of resident positions.

### Program size

The number of resident/fellow positions the program is approved to have.

### Program year

The year of training in the specialty.

### Ratio of FTE faculty to positions

This ratio is calculated by adding the number of full-time paid physicians to one-half the number of part-time paid physicians, and dividing this sum by the number of positions in the program.

### Required length

The accredited length of the program, plus any additional training that is required (not optional) by the program.

### Requires previous GME

The program requires training in another specialty or in a preliminary position prior to entry. Some programs require all residents to have had previous GME, some programs never require previous GME, some programs in special cases will require previous GME for some residents, and some programs may exempt a resident from the requirement.

### Research rotation

A research rotation occurring while training in the program, not to be confused with a research track/non-accredited fellowship. Some programs require a research rotation, for others the rotation is optional, or not available.

### Research track/non-accredited fellowship

A non-accredited research or fellowship year beyond the accredited program length.

### Rural track

Track or separate path solely devoted to rural primary care medicine.

### San Francisco match

The San Francisco match provides a matching service for some residency programs and fellowships, primarily surgical. See www.sfmatch.org.

### Specialty in-service/in-training examination

This examination parallels the specialty's board certification examination, and is typically used to provide feedback to the program on the resident's progress.

### Sponsor

See Institution.

### Survey received

The date the AMA received the program survey which supplies much of the information about the program on FREIDA.

### 360-degree evaluation

An evaluation of the resident/fellow that is completed by attending faculty, peer residents/fellows, nurses and others that have worked with the trainee.

### Twenty-four-hour off duty period

A full 24-hours released from program duties, including beeper or at-home call.

### University-based program

The majority of experience takes place in a hospital that serves as a primary affiliate of the medical school.

### USMLE Step 1 and Step 2

USMLE Step 1 and Step 2 scores may be required by some programs for interview consideration. Some programs post the minimum score they will accept.

### Women's health track

Track or fellowship that provides special training in the area of women's health.

**Match Participation Agreement for Applicants**

**Specialties Matching Service® (SMS®)
For All Matches Opening After January 1, 2023**

**TABLE OF CONTENTS**

## 1.0    INTRODUCTION TO THE SPECIALTIES MATCHING SERVICE

The Specialties Matching Service® (SMS®) encompasses multiple Fellowship Matches and is sponsored by the National Resident Matching Program® (NRMP®), an independent, non-profit organization founded in 1952 for the purpose of providing an orderly and fair mechanism for matching the training preferences of applicants to advanced U.S. residency and fellowship positions with the preferences of advanced residency and fellowship training program directors.

The Specialties Matching Service:

- Provides a system for the confidential selection of applicants to graduate medical education programs using an electronic, proprietary mathematical algorithm;

- Establishes an equitable and uniform time for applicants and programs to submit rank order lists that express their respective preferences;

- Enables applicants to make informed decisions about their chosen medical specialty or advanced residency or fellowship training program(s) free of persuasion; and

- Establishes a binding commitment between the applicant and the program. Neither the applicant nor the program may release the other from the binding commitment without a waiver or deferral granted by the NRMP (Section 9.0).

The SMS is managed through the NRMP's proprietary Registration, Ranking, and Results® (R3®) system which processes an applicant's confidential certified rank order list using a mathematical algorithm to match the preferences of the applicant to the preferences of the program(s). Applicants learn if and where they matched according to published schedules provided by the NRMP.

Applicants who are unmatched after the algorithm has been processed are provided access to the applicable *List of Unfilled Programs* to enable them to secure a training position post-Match.

Applicants are advised to read carefully this Agreement and retain a copy of it for future reference.

## 2.0    ELIGIBILITY

To participate in the SMS, prior to the scheduled start date of the position for which the applicant is applying, the applicant

1. Must have completed the training required for such position; and

2. Must meet the resident/fellow appointment requirements for entry into graduate medical education as prescribed by the Accreditation Council for Graduate Medical Education ("ACGME") in *of the ACGME Institutional Requirements,* which are incorporated into this Agreement by reference.

Each applicant executing this Agreement hereby affirms that he or she will meet those requirements prior to the applicable program start date.

Sponsoring institutions (e.g., teaching hospitals) and advanced residency and fellowship programs may have additional eligibility requirements. Applicants have the right to receive those requirements from each program with which they interview during recruitment, either electronically or in writing, before the applicable Rank Order List Certification Deadline.

 Applicants are responsible for understanding their eligibility to enter their selected training program before certifying their rank order list.

Applicants may not withdraw from the Match after the applicable Rank Order List Certification Deadline.

## 3.0     COUPLES IN THE MATCH

"Couples" are any two individuals participating in the same Fellowship Match who agree to pair their rank order lists for the purpose of matching to a ranked pair of programs.

### 3.1     Change in Eligibility of Individual in a Couple

After the applicable Rank Order List Certification Deadline, if one individual who registered as a couple is withdrawn from, or is determined to be ineligible to participate in the Fellowship Match, and the individuals have not "uncoupled" in the R3 system, the NRMP will:

1. Notify both individuals of the status of the couple; and

2. Uncouple the individuals, remove duplicate programs and "no match" ranks from the rank order list of the eligible individual, and process the rank order list of the eligible individual.

3. If the eligible individual wishes to be withdrawn from the Fellowship Match, they must notify NRMP in writing within 24 hours of being notified of the removal of the couple status.

### 3.2     Failure to Certify Rank Order List

Individuals registered as a couple, and who are eligible to participate in the Fellowship Match, where at least one individual's rank order list was not certified by the applicable Rank Order List Certification Deadline, may contact NRMP within 24 hours of receiving notification of an uncertified list and submit an electronic or written request and consent to support@nrmp.org for NRMP to certify their list. Courtesy certification requests received more than 24 hours after notification of an uncertified list will not be processed by NRMP.

If the individual does not request NRMP to certify their rank order list within 24 hours of receiving notification of an uncertified list, NRMP will:

1. Notify both individuals of the status of the couple; and

2. Uncouple the individuals, remove duplicate programs and "no match" ranks, and process the rank order list of the individual with the certified list through the Fellowship Match.

3. If the individual with the certified list wishes to be withdrawn from the Fellowship Match, they must notify NRMP in writing within 24 hours of being notified of the removal of the couple status.

If applicants participating in the Fellowship Match as a couple do not match to a pair of ranks, the NRMP will not subsequently uncouple the applicants and attempt to match them to a program based on their individual rank order lists.

## 4.0 TERMS AND CONDITIONS FOR PARTICIPATION IN THE SPECIALTIES MATCHING SERVICE

By clicking on the "I Accept" button on the "Sign Match Agreement" screen of the R3 system, the applicant attests to having read this Agreement, and after having done so, agrees to and understands:

1. They will participate in the applicable Fellowship Match within the Specialties Matching Service;

2. The terms and conditions of the Match Participation Agreement;

3. The NRMP is not an employment service and does not oversee the terms of any contract between applicants and training programs;

4. The NRMP does not oversee or control the AAMC ERAS application;

5. The NRMP is not involved in establishing the eligibility requirements for any advanced residency or fellowship position. Training programs have sole responsibility for establishing and communicating all program and institutional eligibility requirements for any position;

6. They must adhere to all rules of communication for the Specialties Matching Service as outlined in the Match Participation Agreement;

7. They must register for the applicable Fellowship Match within the Specialties Matching Service and they must apply directly to the program(s) in which they desire to obtain a position;

8. They must fully disclose academic, professional, and personal experiences that may impact their ability to begin training at the time specified in the appointment contract;

9. Once a match is made between a program and an applicant, a binding commitment exists for the program to offer a training position to the applicant and for the applicant to accept such position absent a waiver from the NRMP;

10. The binding commitment requires applicants to request a waiver from the NRMP should they determine they cannot attend the matched training program(s); and

11. All communications from the NRMP will be transmitted electronically to the email address provided by the applicant at the time of registration, or through an update, in the R3 system. Applicants are solely responsible for the accuracy of their contact information. If an applicant unsubscribes from NRMP emails or notices, the NRMP has no responsibility for sending NRMP information or providing for its receipt.

## 5.0 REGISTRATION DATES AND MATCH FEES

### 5.1 Registration Dates

Match calendars for each Fellowship Match sponsored by the NRMP contain dates for registration and other Match events and are published annually on the NRMP website: www.nrmp.org.

Applicants may only register and participate in one residency or Fellowship Match at a time.

### 5.2 Match Fees

Match fees are published annually on the NRMP website. Match fees provide applicants access to the R3 system, the ability to participate in the applicable Fellowship Match as individuals or as part of a couple, and access to certain Match-related lists and reports. To complete the Match registration procedure, fees must be paid in U.S. dollars through the R3 system. Applicants with unpaid fees will be withdrawn from the Match.

All Match fees are non-refundable. Applicants who authorize a credit card chargeback of fees without the NRMP's written consent may be barred permanently from participation in the NRMP Matching Program.

## 6.0 PARTICIPATION IN THE SPECIALTIES MATCHING SERVICE

The Match process enables applicants to investigate program options and to make informed selection decisions based on their true preferences and on a uniform schedule without coercion or undue or unwanted pressure.

### 6.1 Duty to Act in an Ethical and Professional Manner

All Match participants are required to conduct their affairs in an ethical and professionally responsible manner. The duty under this Agreement:

1. Extends throughout the application, interview, and matching processes; and

2. Through the 45th day following the start date of training as listed in the appointment contract; or

3. Upon conclusion of any NRMP-related waiver review, violation investigation, or appeal process.

NRMP's Code of Conduct for Applicants is available to review at www.nrmp.org.

## 6.2    Completeness, Timeliness, and Accuracy of Information

The NRMP is not responsible for ensuring the accuracy of information exchanged between applicants and programs.  Applicants are responsible for the completeness, timeliness, and accuracy of all information provided. This includes:

1. All information entered on the application either through the Electronic Residency Application Service ("ERAS") or other application process or service;

2. All information provided to agencies and organizations that provide visa services and ECFMG certification;

3. All written, electronic, and verbal information provided to programs and program representatives throughout recruitment, the onboarding cycle, and through the 45th day following the appointment start date; and

4. All written, electronic, and verbal information provided to the NRMP.

Applicants who submit incomplete, misleading, false, or plagiarized information may be deemed to have violated this Agreement.

The omission of any information pertinent to a program's decision to rank an applicant may be deemed a violation of this Agreement. The applicant is responsible for disclosing any information regarding, among other things, the ability to satisfy program requirements; circumstances that may delay or adversely impact an applicant's ability to commence training with a matched program on the program's start date; or information relevant to licensure status or visa status.

The applicant's obligation to submit complete, timely, and accurate information extends through the 45th day following the start date as listed in the appointment contract for the program position obtained through the Fellowship Match.

## 6.3    Confidentiality

Applicant information contained in the R3 system is confidential and accessible only to authorized users. Unauthorized use or disclosure of such information by an applicant is a violation of this Agreement.

At all times, applicants have the right to:

1. Freely investigate all programs participating in the applicable Fellowship Match;

2. Keep confidential all information pertaining to the names and identities of programs to which they have applied or may apply;

3. If applicable, keep confidential all information pertaining to preference signals sent to programs if the applicant is participating in a specialty or subspecialty that has implemented preference signaling;

4. Keep confidential all information pertaining to offers and acceptance of interviews; and

5. Keep confidential all information pertaining to ranking preferences.

Applicants may voluntarily share their rank order lists with their residency program director so the director may support the applicant in the Match process.

**Before the applicable Rank Order List Certification Deadline**

1. Applicants may voluntarily communicate their interest to a program(s); however, applicants may not solicit verbal or written statements from a program(s) implying a commitment to rank the applicant.

2. A program may voluntarily communicate to an applicant that they are viewed favorably and will be ranked by the program; however, programs may not solicit verbal or written statements from an applicant implying a commitment to rank the program.

## 6.4 Restrictions on Persuasion

Applicants have a right to be free of persuasion and should report to the NRMP any violations of these rights. Programs are not authorized to:

1. Request that applicants reveal the numbers, names, specialties, geographic locations, or other identifying information about any program(s) to which they have applied or may apply or with which they have interviewed or may interview;

2. Request that applicants reveal any information about the programs to which they may have sent a preference signal, if applicable;

3. Request that applicants reveal preference signal(s) if in a specialty participating in preference signaling;

4. Request that applicants reveal their ranking preferences;

5. Suggest or inform applicants that placement on a rank order list is contingent upon submission of a verbal, electronic, or written statement indicating the applicant's preference;

6. Make any written, electronic, or verbal offer or contract for appointment to a concurrent year residency or fellowship position before the release of the applicable *List of Unfilled Programs*; and

7. Have any written, electronic, or verbal contact with a matched applicant not matched into their program for the purpose of offering an interview, offering placement in the program, or requesting the applicant apply to a program.

## 7.0   SPECIALTIES MATCHING SERVICE

To participate in the SMS, eligible applicants must register, pay all fees, and submit a certified rank order list electronically through the R3 system before the applicable Rank Order List Certification Deadline. All registered users must enter a unique username and password and must not provide their login credentials to another individual.

### 7.1   Categories of Program Positions

1. Fellowship Position ("F"): A position in a program that begins training after the completion of a core residency training program.

2. Fellowship Subspecialty Position ("S"): A position in a program that begins after the completion of a fellowship training program.

### 7.2   Submission of Rank Order Lists

Applicants must enter and certify their final rank order list in the R3 system before the applicable Rank Order List Certification Deadline. Certification of the rank order list will confirm the applicant's full participation in the Fellowship Match and agreement to

1. Adhere to the binding commitment to accept an appointment if a match results; and

2. Start training in good faith (i.e., with the intent to complete the program) on the date specified in the appointment agreement.

Non-U.S. citizen applicants requiring a visa are responsible for confirming the institution's willingness to sponsor the visa-type intended by the applicant before certifying their rank order list.

The NRMP will not create or modify any applicant's rank order list except where noted in this Agreement.

Applicants may enter their rank order lists in more than one session and may modify their lists multiple times before the applicable Rank Order List Certification Deadline.

1. All entries or modifications to a rank order list require applicants to certify or recertify the list before the applicable Rank Order List Certification Deadline.

2. Applicants whose rank order lists are not certified before the published deadline may, within 24 hours of receiving a courtesy notification of an uncertified list, submit an electronic or written request and consent to support@nrmp.org for the NRMP to certify their list.

    a. Certification requests received more than 24 hours after the courtesy notification of an uncertified list will not be processed by the NRMP.

    b. Only the rank order list displayed in the R3 system at the time of the applicable Rank Order List Certification Deadline will be certified.

    c. Once the courtesy certification is complete, the NRMP will not uncertify the rank order list.

## 7.3    Notification of Match Status

At the designated time on the applicable Match Day, the NRMP will notify all applicants who submitted a certified rank order list of their matched status and match results via the R3 system and through a courtesy email.

Upon the release of match status, applicants are considered:

1. **Matched** if matched into any advanced residency or fellowship position; or

2. **Unmatched** if not matched into any position.

## 7.4    Notification of Match Results

At the designated time on the applicable Match Day, the NRMP will release the Match results to applicants via the R3 system and through a courtesy email.

Applicants who are matched:

1. Are in a binding commitment and must accept the appointment(s) offered by the fellowship training program; and

2. Must meet all eligibility and hiring requirements of the program(s) and the institution(s) in which the training appointment(s) is located.

    a. Each appointment is subject to the official policies of the appointing program(s) and institution(s) in effect on the date the program(s) submits its rank order list.

b. Applicants requiring a visa must confirm the institution's willingness to sponsor the visa-type intended by the applicant before certifying their rank order list.

The *List of Unfilled Programs* for the applicable Fellowship Match will be posted to the R3 system at the designated time on Match Day and will remain available to unmatched applicants until the published date.

Programs and matched applicants may freely communicate, and programs may initiate their institution's onboarding processes after Match results are made available on Match Day, as published in the applicable Fellowship Match calendar.

## 7.5    Communication About Appointments

Between the applicable Rank Order List Certification Deadline and the notification of Match status and results, applicants may not apply for, discuss, interview for, or accept any position that would run concurrent with positions offered in the applicable Fellowship Match.

Violations of any policies pertaining to communication between programs and applicants must be reported to the NRMP at policy@nrmp.org.

## 8.0    WITHDRAWAL FROM THE MATCH

Applicants may withdraw themselves from the applicable Fellowship Match but must do so through the R3 system prior to the applicable Rank Order List Certification Deadline. Withdrawn applicants will not have their rank order list used in the applicable Fellowship Match.

Applicants who accept a concurrent year residency or fellowship position outside the Match or through any other national matching plan must withdraw from the Match through the R3 system prior to the applicable Rank Order List Certification Deadline. Failure to withdraw from the SMS prior to the applicable Rank Order List Certification Deadline shall be a breach of this Agreement.

### 8.1    Withdrawal of Applicants by NRMP

The NRMP may withdraw an applicant from the applicable Fellowship Match for the following causes:

1. Applicants registered in both the Canadian Resident Matching Service ("CaRMS") and the SMS and who match through CaRMS to a concurrent year position.

    a. In those years in which CaRMS has an earlier schedule, applicants who match through CaRMS are ineligible to match and to participate in the SMS for concurrent year NRMP positions. Applicants will be withdrawn by the NRMP after the applicable Rank Order List Certification Deadline.

b. In those years when CaRMS has a later schedule, applicants registered for CaRMS who match in the NRMP will be withdrawn from the CaRMS Match.

2. Applicants with unpaid NRMP fees. Those applicants will be withdrawn from the applicable Fellowship Match, will not be allowed access to the *List of Unfilled Programs*.

3. Applicants for whom the NRMP believes it has credible evidence that they have violated the terms of this Agreement.

Upon withdrawal from the Match for alleged violation of the terms of this Agreement, the applicant's status in the R3 system will note "Pending Action," which will remain in effect until the applicant has waived or exhausted all avenues of appeal. Applicants withdrawn from the SMS may appeal the action through the NRMP "Violations Policy", which may be found on the NRMP website.

The NRMP's authority to withdraw an applicant from the SMS under this section is in addition to its authority to impose sanctions for violations of this Agreement. The decision by the NRMP to withdraw an applicant under this section shall remain in place and shall not be subject to any suspension in the event the applicant contests the withdrawal or other action by the NRMP under the dispute resolution process set forth in Section 17.0.

## 9.0    BINDING COMMITMENT

Upon conclusion of the applicable Fellowship Match, matched applicants:

1. Are in a binding commitment with the program and must accept an appointment as matched or offered:

    a. Applicants with a match commitment who seek a concurrent year position, absent a waiver or deferral from the NRMP, shall be presumed to have violated this Agreement.

2. Must begin training on the start date specified in the appointment contract with the intent to complete the program:

    a. The binding commitment will be deemed to have been honored by the applicant so long as the applicant enters and remains in the training program through the first 45 calendar days after the start date of the relevant appointment contract.

    b. The binding commitment exists through the first 45 calendar days of the start date of the relevant appointment contract.

    c. Programs terminating a resident within 45 days of the start date specified in the appointment agreement, without having an approved waiver or deferral from the NRMP, will be in violation of this Agreement.

d.  Applicants who give notice of resignation, resign, or vacate a position within 45 days of the start date specified in the appointment agreement, without having an approved waiver or deferral from the NRMP, will be in violation of this Agreement. Programs must report such violations to policy@nrmp.org.

Each appointment is subject to the official policies of the appointing institution and program (e.g., expected training credentials, background checks, drug screens, visa status) in effect on the applicable Rank Order List Certification Deadline.

## 10.0    WAIVER OR DEFERRAL OF MATCH RESULTS

**Waiver:** The release of Match participants from the binding commitment following the Fellowship Match.

**Deferral:** A one-year delayed start of training mutually agreed to by the matched applicant and the program.

Neither applicants nor programs may release each other from a matched position. A waiver or deferral of the binding commitment may be obtained only from the NRMP. Applicants are encouraged to review the Waiver and Deferral policy on the NRMP website. The terms of the Waiver and Deferral Policy are incorporated herein and binding upon all Match participants.

A waiver or deferral may be considered by the NRMP:

1.  For circumstances demonstrating an unanticipated serious and extreme hardship or change of specialty; or

2.  If NRMP determines the applicant is ineligible to begin training.

Applicants considering a waiver or deferral request:

1.  Shall review the Waiver and Deferral Policy on the NRMP website (www.nrmp.org);

2.  Shall submit the request in accordance with the directions provided on the NRMP website;

3.  Shall demonstrate to the reasonable satisfaction of the NRMP that the criteria necessary for approval and issuance of a waiver or deferral are present;

4.  Shall provide complete, timely, and accurate information to the NRMP in connection with its waiver or deferral review;

5.  Shall not decline the matched position until the waiver or deferral request has been decided; and

6.  Shall not apply, interview for, or accept a position in another program until the waiver or deferral request has been approved.

Applicants shall promptly notify the NRMP of a waiver or deferral request received from a program.

NRMP's decision is final and is not subject to challenge in arbitration, by judicial review, or by review of a third party. NRMP may grant a deferral of up to one year at the request of either a program or an applicant if arbitration proceedings have been initiated and the outcome is pending.

Absent a waiver or deferral from the NRMP failure to honor this binding commitment will be considered a violation of this Agreement.

## 11.0   VIOLATIONS

Applicants are responsible for conducting their affairs in an ethical, professional, and responsible manner throughout the application, interview, and matching process.

Applicants have a right to expect institutions and programs also to conduct their affairs in an ethical, professional, and responsible manner throughout the application, interview, and matching processes.

Known or suspected violations of any applicable Match Participation Agreement must be reported to the NRMP. Reports of a violation of Match policy may be made anonymously.

### 11.1   Alleged Violations

At its discretion, the NRMP will investigate alleged violations of this Agreement, including but not limited to:

1. Failure to provide complete, timely, and accurate information during the application, interview, and matching processes;

2. Attempts to subvert or circumvent eligibility requirements or the matching process;

3. Failure to accept an appointment as required by the results of a Fellowship Match outcome;

4. Failure to engage in ethical and/or professionally responsible behavior; or

5. Any other irregular behavior or activity that occurs in connection with registration, the submission or modification of a rank order list, and/or the applicant's commitment to honor the Match outcome.

### 11.2   Violations Policy and Procedure

The NRMP Policies and Procedures for Reporting, Investigation, and Disposition of Violations of NRMP Agreements ("Violations Policy") may be found on the NRMP website and shall govern the handling of match violations.

If the NRMP receives sufficient, credible information that a violation of this Agreement may have occurred, the NRMP may initiate an investigation in accordance with the Violations Policy. Applicants must provide complete, timely and accurate information to the NRMP in connection with its violation investigation.  The terms of the Violations Policy (including, but not limited to, the consequences of a confirmed violation) are incorporated herein and binding upon all Match participants.

## 11.3    Withdrawal of Applicant Due to Suspected Violation

### 11.3.1  Authority

The NRMP's authority to withdraw an applicant or program from the SMS under this section is in addition to its authority to impose sanctions for violations of this Agreement.  At any time before the applicable Fellowship Match results are released, the NRMP may withdraw any applicant from the Match without first affording an opportunity for a hearing if the NRMP believes it has credible evidence that:

1.  The applicant has violated the terms of this Agreement; and

2.  Absent such summary withdrawal, the integrity of the Match is in jeopardy.

### 11.3.2  Pending Action

Upon withdrawal from the applicable Fellowship Match due to an alleged violation, the applicant's status in the R3 system will note "Pending Action," which will remain in effect until the applicant has waived or exhausted all avenues of appeal as outlined in the NRMP Violations Policy.

The matched program may not fill the applicant's position during the NRMP's investigation until the NRMP has issued a Final Report or granted a waiver, whichever is earlier.

If the violation investigation has not concluded by the start date of training, the program shall begin training the matched applicant unless NRMP has granted a waiver or issued a deferral to the next training year.

## 11.4    Confirmed Violations

If the NRMP's investigation of an alleged violation results in a finding that an applicant has committed a violation of this Agreement, the applicant will be withdrawn from the Match and sanctions levied as outlined in the Violations Policy.

## 12.0 USE OF MATCH INFORMATION

### 12.1 Applicant Use of Match Information

Applicants may use the R3 system and the information contained therein solely for the purpose of their participation in the SMS. Applicants may not share with any individual any Match information from or maintained in the R3 system, including but not limited to, information from the *List of Unfilled Programs*.

Applicants may not copy, distribute, post, or make publicly available in any other way, any Fellowship Match information from or maintained in the R3 system, including information from the *List of Unfilled Programs*. URLs that link to information from the R3 system or PDFs that have been created, copied, or downloaded from the R3 system shall not be made public or redistributed in any form even if the information already is in the public domain.

Unauthorized disclosure of Fellowship Match information by applicants is considered a violation of this Agreement and may result in sanctions to the applicant.

### 12.2 NRMP Use of Match Information

Each applicant authorizes the NRMP to request, obtain, transmit and receive identifying information (including information in the R3 system, individual applicant USMLE scores, COMLEX scores, Alpha Omega Alpha membership, and information regarding demographics and volunteer and work experiences) to and from authorized users, including the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the Association of American Medical Colleges, the American Medical Association, the Educational Commission for Foreign Medical Graduates, the Canadian Resident Matching Service, the National Board of Medical Examiners, the National Board of Osteopathic Medical Examiners, U.S. MD-granting medical schools, U.S. DO-granting medical schools, and other organizations engaged in postgraduate medical education for purposes of:

1. Collecting and verifying data submitted by the applicant;

2. Establishing postgraduate training databases;

3. Conducting a Matching Program;

4. Performing research;

5. Establishing a Match; or

6. Providing technology applications and service tools offered by the NRMP.

### 12.2.1 Disclosure

The NRMP will not disclose applicant personal information that is clearly and uniquely identifiable to any applicant, program, institution, or medical school except in response to a subpoena or an order from a court of competent jurisdiction. For each applicant who authorizes the NRMP to use applicant information for research purposes, the NRMP may provide such identifiable information only to reputable organizations engaged in undergraduate, graduate or postgraduate education solely for the purposes of performing joint research under strict, binding terms of a confidential data sharing agreement.  At no time will the NRMP allow applicant personal information that is clearly and uniquely identifiable to be disclosed in publications, presentations, and reports resulting from such research.

The NRMP may anonymize and/or aggregate applicant information and use it for its own reporting purposes and contribute such anonymized, aggregated information to national databases or for NRMP-approved research purposes, technology applications and service tools offered by the NRMP.

### 12.2.2 Ranking and Match Outcome Information

For the avoidance of doubt, a rank order list submitted by an applicant is confidential and the NRMP will not disclose or release applicant ranking information that is clearly and uniquely identifiable to any applicant, program, institution, or medical school except in response to a subpoena or an order from a court of competent jurisdiction. For each applicant who authorizes the NRMP to use applicant information for research purposes, the NRMP may provide such identifiable information only to reputable organizations engaged in undergraduate, graduate or postgraduate education solely for the purposes of performing joint research under strict, binding terms of a confidential data sharing agreement. At no time will the NRMP allow applicant ranking and/or match outcome information that is clearly and uniquely identifiable to be disclosed in publications, presentations, and reports resulting from such research.

The NRMP may anonymize and/or aggregate rank order list and/or match outcome information and use it for its own reporting purposes and contribute such anonymized, aggregated information to national databases or for NRMP-approved research purposes, technology applications and service tools offered by the NRMP.

Each applicant authorizes the NRMP to release applicant Fellowship Match results to each program that ranked the applicant on the program's rank order list, to the specialty representative to the NRMP, and to those program directors who request such information to verify whether an applicant was matched.

Each applicant also authorizes the NRMP to release the location of current or prior residency training, as provided to the NRMP by the applicant, in a report to

the applicant's Main Residency Match® program director for the purpose of verifying where the applicant matched for a fellowship position.

Each applicant also authorizes the NRMP to release any information provided by such applicant to other matching programs for the purpose of ensuring the applicant does not match to concurrent year positions. Each applicant also authorizes the NRMP to post appointment information in the R3 system Applicant Match History.

## 13.0   REPRESENTATION AND WARRANTIES

Each applicant represents and warrants to the NRMP that all of the information provided, or that will be provided, by such applicant to the NRMP is at all times complete, timely, and accurate to the best of such applicant's knowledge at the time such information was or will be provided. Each applicant further represents that he/she has authorized all institutions and individuals who may possess this information to disclose it to the NRMP for purposes of verification.  Each applicant further represents that their unique log in information to access the R3 system will not be shared with or used by any other individual to access the system.  Moreover, each applicant represents that he/she has read, understood, and agrees to the NRMP's Privacy Statement.

## 14.0   DISCLAIMERS

The parties acknowledge that the fees charged by the NRMP for participation in the Specialties Matching Service include no consideration for any assumption by the NRMP of the risk of any damages that may arise in connection with any program's or applicant's participation in the SMS or utilization of the R3 system.

Each party agrees that neither:

1.   the NRMP,

2.   any vendor providing equipment, software, or services to the NRMP ("Vendor"), nor

3.   any director, officer, employee, affiliate, or agent of the NRMP, or any Vendor,

will be liable for any loss, damage, cost, or expense whatsoever, direct or indirect, regardless of the cause, that may arise out of, or be in any way related to, this Agreement, the use of the Specialties Matching Service, the R3 system, or the automated systems and services utilized by the NRMP to implement the Specialties Matching Service or to send notices, including, but not limited to: (a) the suspension or termination of, or the inability to use, all or any part of the R3 system; (b) the erroneous transmission of any data or the transmission of any erroneous data; (c) any failure or delay suffered or allegedly suffered by any party in receiving or sending any rank order list or other information or in certifying a rank order list, however caused; (d) the delivery or transmission of any virus, worm, or other disruptive device; or (e) any other cause in connection with the furnishing of services or notices by the NRMP or the performance, maintenance, or use of, or inability to use, all or any part of the R3 system. The foregoing will apply regardless of whether a claim arises in contract, tort, negligence, strict liability, or otherwise.

The automated systems and services utilized by the NRMP to implement the Specialties Matching Service and the R3 system are provided "AS IS" and "AS AVAILABLE." **NONE OF THE NRMP, ANY VENDOR, OR ANY OF THEIR DIRECTORS, OFFICERS, AGENTS, EMPLOYEES, OR AFFILIATES MAKES ANY WARRANTY OR REPRESENTATION OF ANY KIND, EXPRESS OR IMPLIED, WITH RESPECT TO SUCH SERVICES, THE R3 SYSTEM, OR THE SPECIALTIES MATCHING SERVICE, OR TO THE ACCURACY, COMPLETENESS, SECURITY, TIMELINESS, OR RELIABILITY OF THE INFORMATION TO WHICH ANY PARTY HAS ACCESS OR TRANSMITS OR RECEIVES THROUGH THEM OR THROUGH ANY OTHER AUTOMATED SYSTEM. ALL IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, TITLE, AND NON-INFRINGEMENT ARE EXPRESSLY EXCLUDED.**

No oral or written information or advice given by the NRMP, any Vendor, or any of their directors, officers, agents, affiliates, or employees will create a warranty, and no party may rely on any such information or advice. There is no assurance that the information to which the parties have access through the R3 system will be accurate, complete, secure, timely, or reliable, or that the R3 system or the automated services utilized by the NRMP will be error-free or operate without interruption. In particular, and without limiting the generality of the foregoing, the NRMP makes no warranty that certified rank order lists processed through use of such automated services will be properly executed. Each program and applicant is solely responsible for verifying that the certified rank order list has been duly entered and certified.

## 15.0    LIMITATION OF LIABILITY

IN NO EVENT WILL THE NRMP OR ANY VENDOR OR AFFILIATE BE LIABLE FOR ANY DAMAGES AS A RESULT OF ANY NEGLIGENT ACT OR OMISSION OF THE NRMP OR ANY VENDOR OR AFFILIATE, IRRESPECTIVE OF WHETHER THE INJURED PARTY IS A PROGRAM, AN APPLICANT, OR A THIRD PARTY.

## 16.0    NOTICES

All notices to the NRMP, must be given either by email at support@nrmp.org or through the R3 system and are effective upon receipt. The NRMP is not responsible for delays in email or Internet service. Any notices or documents received by the NRMP after the relevant deadline date will not be considered.

All notices, to applicants or programs will be given either by (a) email to the email address provided by such party to the NRMP upon submission of such party's registration in the R3 system or (b) through the R3 system while the applicant or program is logged on to the site. Such notices to applicants or programs given by email will be deemed given twenty-four (24) hours after sending, unless the sending party is notified that the email address is invalid or that the message was not delivered, or if the receiver has voluntarily unsubscribed from NRMP emails or notices. All notices given by the NRMP during an applicant's or program's session on the R3 system will be deemed given at the time of such session.

## 17.0    DISPUTE RESOLUTION

Except for waiver determinations that are final when made by the NRMP and not subject to arbitration, judicial review, or review by any third party, as provided in this Agreement, all other disputes arising out of, or related to, the Specialties Matching Service, this Agreement, or the breach thereof, between or among the NRMP and any applicant or program participating, or seeking participation, in the Specialties Matching Service shall be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association then in effect (as modified below and excluding Procedures for Large, Complex Disputes), unless the parties to the dispute mutually agree otherwise. The arbitration hearing shall commence within six months of filing the demand for arbitration or at another time agreeable to the NRMP. Notwithstanding the foregoing, no arbitrator shall have power to adjudicate any dispute as a class arbitration or as a consolidated arbitration without the express consent of all the parties to any such dispute, and every arbitrator shall return a reasoned award in writing, setting forth the factual findings and legal conclusions that are the basis for the determination.  In addition, no arbitrator shall have the power to modify any sanctions imposed by the NRMP unless: (1) the arbitrator determines there is no basis in fact for a finding of violation; or (2) the arbitrator finds that the sanctions imposed by the NRMP are either arbitrary and capricious or outside the scope of potential sanctions set forth in this Agreement and the Violations Policy.

Notice of the demand for arbitration must be filed in writing with all other parties to the arbitration and with the American Arbitration Association.  A demand for arbitration in a matter that is covered by the Violations Policy must be made in accordance with the Violations Policy.  The arbitrator(s) must conduct all arbitration proceedings in the Office of the NRMP in Washington, DC or at such other location in Washington, DC as mutually agreed upon by the parties.  Each party will share equally in the cost of arbitration, except that the party requesting arbitration shall be solely responsible for paying the filing fee required by the AAA Standard Fee Schedule, including the Initial Filing Fee and the Case Service Fee, and the party requesting arbitration must further file the AAA form entitled "Demand for Arbitration – Commercial".  The burden shall be on the party requesting arbitration to demonstrate by clear and convincing evidence that an adverse decision by the NRMP was without basis-in-fact or in violation of this Agreement.  The award by the arbitrator or arbitrators shall be final.  Judgment upon the award rendered may be entered in any court having jurisdiction thereof, so long as the arbitrator(s) acted in good faith.

The arbitrator(s) may construe and interpret, but may not vary or ignore, the terms of this Agreement.  The arbitrator(s) shall not have the power to make an award that is inconsistent with the provisions of this Agreement or with District of Columbia substantive law.

## 18.0    LIMITATION OF ACTION

No claim or cause of action, regardless of form, arising out of or related to the Specialties Matching Service, this Agreement, or the breach thereof, or any other dispute between the NRMP and any applicant or program participating, or seeking participation, in the Specialties Matching Service, may be brought in any forum by any party more than 30 calendar days after the cause of action has accrued, regardless of any statute, law, regulation, or rule to the contrary ("Limitation Period"). The Limitation Period shall commence the day after the day on which the cause of action accrued.  Failure to institute an arbitration proceeding within the Limitation Period will constitute an absolute bar and waiver of the institution of any proceedings,

whether in arbitration, court, or otherwise, with respect to such cause of action.  A cause of action that has become time-barred may not be exercised by way of counter claim or relied upon by way of exception.

In addition, any party who desires to contest a decision of a Review Panel of the NRMP must notify the NRMP in writing of its 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 within 30 calendar days of receipt of such report, in accordance with the terms of the Violations Policy.  If notice of a party's intent to seek arbitration is not received in writing 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 written demand for arbitration 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.

## 19.0    GENERAL

This Agreement is governed by the laws of the District of Columbia, excluding its choice of laws provisions, and the agreed upon venue for any dispute arising from this Agreement is the District of Columbia.

The headings of the Sections of this Agreement have been inserted for convenience of reference only and shall in no way restrict or otherwise affect the construction of the terms or provisions of this Agreement.  Unless indicated otherwise, references in this Agreement to Sections are to Sections of this Agreement.

If any provision of this Agreement is found in any arbitration proceeding or by any court of competent jurisdiction to be invalid, illegal, or unenforceable, that provision shall be modified to the minimum extent necessary to achieve the purpose originally intended, if possible, and the validity, legality, and enforceability of the remaining provisions will not be affected or impaired and are to be enforced to the maximum extent permitted by applicable law.  If any remedy set forth in this Agreement is determined to have failed of its essential purpose, then all other provisions of this Agreement will remain in full force and effect.

Failure of any party to act or exercise its rights under this Agreement upon the breach of any other terms hereof by any other party is not to be construed as a waiver of such a breach or prevent such party from later enforcing compliance with any or all of the terms hereof. This Agreement contains the entire agreement between the parties with respect to the Specialties Matching Service and its results.  Any representations, promises, or conditions not incorporated in this Agreement will not be binding upon any of the parties.  No modification of this Agreement shall be effective unless in writing and executed by the party against whom it is to be enforced.

## 20.0    APPLICANT AUTHORIZATION FOR RELEASE OF TEST SCORES AND ANONYMIZED DATA

By my electronic signature and as of the date this Agreement is submitted to NRMP, I hereby authorize National Board of Medical Examiners and the National Board of Osteopathic Medical Examiners, to release, verify, and transmit to NRMP upon its request certain test score data, in particular my USMLE scores, COMLEX scores, or other test score(s) utilized in the Match

process.  I understand and agree that the test score data shall be used to verify test score information provided by me or about me by a testing service or other entity relevant to the graduate medical education matching process.

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# Match Participation Agreement for Institutions

## 2022 Main Residency Match® and Supplemental Offer and Acceptance Program® (SOAP ®)

## Specialties Matching Service® for all Fellowship Matches Opening after September 15, 2021

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**1.0 INTRODUCTION TO THE MATCHING PROGRAM**
The Main Residency Match ("the Match") and the Specialties Matching Service comprise the Matching Program sponsored by the National Resident Matching Program® (NRMP®), an independent, non-profit organization founded in 1952 for the purpose of providing an orderly and fair mechanism for matching the training preferences of applicants to U.S. residency and fellowship positions with the preferences of residency and fellowship training program directors.

The Matching Program:

- Provides a system for the confidential selection of applicants to graduate medical education programs using an electronic, proprietary mathematic algorithm;

- Establishes an equitable and uniform time for applicants and programs to submit rank order lists that express their respective preferences;

- Enables programs to make informed decisions about applicants in an orderly manner and free of persuasion; and

- Establishes a binding commitment between the applicant and the program(s). Neither the applicant nor the program may release the other from the binding commitment without a waiver or deferral granted by the NRMP (Section 10.0).

The Matching Program is managed through the NRMP's proprietary Registration, Ranking, and Results® (R3®) system which processes an applicant's and a program's certified Rank Order List using a mathematical algorithm to match the preferences of the applicant to the preferences of the program(s). Programs learn which applicant(s) matched according to published schedules provided by the NRMP.

Only programs from institutions that have registered with the NRMP and agreed to abide by the terms of the applicable Agreement may participate in the Matching Program. Such programs also must register individually with the NRMP and agree to abide by the terms of the applicable Match Participation Agreement.

The Specialties Matching Service® (SMS®) is provided by the NRMP to program directors' groups (i.e., associations of training program directors) whose programs offer entry level positions only to applicants who have completed two or more years of graduate medical education.

The NRMP requires the program directors' group of each specialty participating in the SMS to execute annually an "NRMP Program Directors' Annual Participation Agreement" that commits active participation of at least 75 percent of the group's eligible programs and a minimum of 75 percent of all available positions in the specialty for that year. Specialties Matching Service Match sponsors may voluntarily elect to implement a policy whereby all participating programs are required to register and attempt to fill all positions in the Match. Positions may be offered through the SMS to physician graduates of medical schools in the United States and elsewhere who meet the eligibility requirements set forth by the NRMP.

Any breach by a sponsoring institution of any of its obligations under this Agreement may be investigated by the NRMP pursuant to its Policies and Procedures for Reporting, Investigation,

and Disposition of Violations of NRMP Agreements and may result in penalties to the institution as described in Section 12.0.

Institutions are advised to read carefully this Agreement and retain a copy of it for future reference.

## 2.0 INSTITUTION LEADERSHIP

### 2.1 Institutional Official

Each institution with programs participating in the Matching Program shall designate an Institutional Official to be responsible for overseeing the Match processes. All changes made by a program concerning its positions must be approved by the institutional official responsible for that program by the applicable Quota Change Deadline. The institutional official has the authority to modify and certify program rank order lists; however, such modifications and certifications must be done in collaboration and with the approval of the program director.

In addition to the general responsibilities of the NRMP institutional official for overseeing the Match process and communicating with the NRMP, the institutional official shall:

1. Ensure adherence to all policies governing the Match as outlined in this Agreement;

2. Provide all information required for the registration of the institution and each of its programs that desire to participate in the Matching Program and ensuring the accuracy of such information including, but not limited to, the number and type of positions offered by each program.

3. Ensure that all of the institution's programs that desire to participate in the Matching Program execute a Match Participation Agreement prior to the applicable Quota Change Deadline.

4. Ensure that all of the institution's programs that participate in the Main Residency Match register and attempt to fill all of their positions in the Match or another national matching plan.

5. Ensure that all of the institution's programs that participate in a Specialties Matching Service Match that have implemented the All In Policy register and attempt to fill all of their positions in the *SMS* Match.

6. Communicate all quota changes, additions, withdrawals, and other changes in and/or reversions of the positions offered by any of such institution's programs through the *R3* system prior to the applicable Quota Change Deadline. Exceptions to this deadline may be requested by the institutional official for cases of extreme emergency, such as loss of funding or

accreditation, or to accommodate the results of earlier matching programs.

7.  Ensure that prior to the release of the results of the Main Residency Match, all programs sponsored by the institution, regardless of Match participation status, offer positions to sponsored applicants (U.S. MD and DO senior students) only through the Main Residency Match or another national matching plan.

8.  Ensure that none of the programs sponsored by the institution, regardless of Matching Program participation status, discusses, interviews for, or offers a position to an applicant who has matched to a concurrent year position through the Matching Program.

9.  Ensure that none of the programs sponsored by the institution, regardless of Matching Program participation status, discusses, interviews for, or offers a position to an applicant between the applicable Rank Order List Certification Deadline and the release of Match results.

10. Ensure that none of the programs sponsored by the institution, regardless of Matching Program participation status, discusses, interviews for, or offers a non-Match position to a *SOAP*-eligible applicant during Match Week.

11. Ensure that all of its programs that offer residency or fellowship positions through the Matching Program will be either

    o   Accredited by the Accreditation Council for Graduate Medical Education ("ACGME") or another accrediting body acceptable to NRMP;

    o   A combined program that is approved or recognized by the American Board of Medical Specialties or by the respective specialty board that is responsible for board certification of residents who successfully complete the combined program; or

    o   In compliance with the eligibility requirements set forth in section 3.1 of this Agreement.

    Eligibility must be met by the applicable Rank Order List Certification Deadline.

12. Assume oversight in the R3 system of unaccredited fellowship programs not under the governance of the institution. Unaccredited programs for which the institutional

official does not assume oversight will not be permitted to participate in the Match.

13. Check the accuracy of all information submitted by program directors for registration and subsequent changes and confirming such information and changes through the appropriate pages of the R3 system. The institutional official has the authority to modify and certify program rank order lists; however, any changes made by the institutional official to a program's rank order list must be done in collaboration with and with the approval of the program director.

14. Promptly communicate to the program directors all information sent from the NRMP that is relevant to such program directors.

15. Ensure that each of the institution's programs provides complete, timely, and accurate information to interviewees, including a copy of the contract the applicant will be expected to sign if matched to the program, if such contract is available, or a copy of the contract currently in use. The NRMP institutional official also must ensure that each of the institution's programs provides institutional policies on visa status and eligibility for appointment to a residency or fellowship position, as applicable.

16. Ensure that the institution's programs do not ask for verbal or written commitments from applicants indicating how they intend to rank any program or whether they will accept a position that is offered during SOAP.

17. Assume responsibility for communicating NRMP policies to the institution's programs, faculty, and staff regardless of their Match participation status.

18. Arrange for prompt payment to the NRMP of all fees owed by the institution or any of its programs.

19. Ensure that all of the institution's passwords are kept confidential and notifying the NRMP immediately if the institution has any reason to believe that any of the institution's passwords have been discovered or used by a third party or that there has been any other breach of security.

## 2.2 Institutional Administrator

The NRMP institutional official may designate an institutional administrator to assist with the oversight of the matching process.

The NRMP institutional administrator:
1. Shall adhere to the policies outlined in this Agreement;

2. Have a username and password to access the R3 system that is separate and distinct from the institutional official;

3. Is prohibited from accessing the R3 system using the institutional official or any other user's username and password;

4. Is prohibited from sharing their username and password with any other user;

5. May enter or change selected institution and program reference data, which may require subsequent approval by the institutional official, through the R3 system.

## 3.0 PROGRAMS IN THE MATCHING PROGRAM

### 3.1 Eligibility

#### 3.1.1 Eligibility: Main Residency Match

To participate in the Match and be eligible to offer training positions through the Match, as of the Rank Order List Certification Deadline, a program must:

1. Be accredited by the Accreditation Council for Graduate Medical Education ("ACGME"); or

2. Be a combined program approved or recognized by the American Board of Medical Specialties ("ABMS") or by the respective specialty board applicable to the training program;

3. Have secured funding sufficient to train each matched resident for the duration of the training program; and

4. Be activated for participation in the Match by the institutional official through the R3 system by the published deadline.

Programs participating in the Match agree to register and attempt to fill all positions through the Match or another national matching plan.

#### 3.1.2 Eligibility: SMS Matching Program

The NRMP may, in accordance with the policies and advice of the sponsoring program directors' group, be selective in determining which programs are eligible to participate in the SMS Match for that specialty. Only programs in a specialty for

which an SMS Match is being conducted may offer positions through the SMS. Positions are titled "residency" or "fellowship" depending upon the specialty for which the SMS Match is being conducted.

To be eligible to offer positions through an SMS Match, as of the applicable Rank Order List Certification Deadline for such SMS Match a program must be either

1. Accredited by the ACGME or another entity acceptable to NRMP;

2. Affiliated with an ACGME-accredited program in the primary discipline; or

3. Lead to certification or endorsement and oversight by a board recognized by the American Board of Medical Specialties.

The program also must have funding to train matched fellows.

## 3.2 Categories of Program Positions

1. Categorical Position ("C"): Post graduate year one (PGY-1) position in programs that provide the full training required for board certification in a specialty.

2. Categorical Primary Care ("M"): PGY-1 positions in medicine and pediatrics that provide a training emphasis on primary care.

3. Preliminary Positions ("P"): One-year positions in transitional or specialty programs.

4. Advanced Position ("A"): Positions in specialty programs that begin the year after the Main Residency Match and after one or more years of required preliminary training.

5. Reserved Positions ("R"): PGY-2 positions in specialty programs that begin in the year of the Main Residency Match and are reserved for physicians with prior graduate medical education. These positions are also known as "Physician Positions".

6. Fellowship (F) positions in programs that begin training subsequent to the completion of a core resident training program.

7. Fellowship subspecialty (S) positions in programs that begin training subsequent to the completion of a fellowship. training program.

### 3.3 Program Leadership and Staff

**3.3.1 Program Director:** The institutional official shall designate a qualified program director who is responsible for ensuring the accuracy of the program's information and adherence to all policies governing a Match. All changes made by a program director concerning Match participation and positions must be approved by the institutional official on or before published Match deadlines.

The program director shall:

1. Ensure adherence to all policies governing a Match as outlined in the applicable Match Participation Agreement;

2. Not share username and password information with any other individual;

3. Provide accurate program information in the R3 system including but not limited to contact information and the number and type of positions offered;

4. Ensure that all changes in Match participation and positions are approved by the institutional official;

5. Execute the applicable Match Participation Agreement prior to the Quota Change Deadline;

6. Register and attempt to fill all of their positions in the Main Residency Match, if applicable, or another national matching plan;

7. Agree to select U.S. MD and DO senior students ("sponsored applicants") only through the Main Residency Match or another national matching plan;

8. Submit and certify a rank order list prior to the Rank Order List Certification Deadline; and

9. If desired, appoint a program coordinator to assist in the matching process.

**3.3.2 Program Coordinator:** Each program may designate a program coordinator to assist with the matching processes. The program coordinator:

1. Must adhere to the policies outlined in this Agreement;

2. Shall have a username and password to access the R3 system that is separate and distinct from the program director;

3. Is prohibited from accessing the R3 system using the program director or any other user's username and password;

4. Is prohibited from sharing their username and password with any other user;

5. May view all program data available through the R3 system, enter or change program data with the exception of the program's quota and the SOAP participation status, if applicable, if authorized by the program;

6. May enter rank order lists and SOAP preference lists into the R3 system if authorized by the program; and

7. Is prohibited from certifying rank order lists and SOAP preference lists in the R3 system.

## 4.0 TERMS AND CONDITIONS FOR PARTICIPATION IN THE MATCHING PROGRAM

By clicking on the "I Accept" button on the "Sign Match Agreement" screen of the R3 system, designated institutional leadership attests to having read this Agreement, and after having done so, agrees to and understands:

1. The institution will participate in the Match;

2. The terms and conditions of the Match Participation Agreement;

3. The NRMP is not an employment service and does not oversee the terms of any contract between programs and applicants;

4. The NRMP does not oversee or conduct services related to the application;

5. The NRMP is not involved in establishing the eligibility requirements for any residency position. Training programs have sole responsibility for establishing and communicating all program and institutional eligibility requirements for any position;

6. The institution must adhere to all rules of communication for the Matching Program as outlined in the Match Participation Agreement;

7. The institution's programs must disclose to applicants all eligibility requirements for training set forth by the sponsoring institution and the program during the recruitment period and before the applicable Rank Order List Certification Deadline. These requirements may include pre-employment testing (e.g., illicit drug screening), background checks (e.g., criminal, financial, etc.), visa sponsorship, and any other requirement(s). Programs must be able to demonstrate that eligibility requirements are made available to each applicant during recruitment and before the applicable Rank Order List Certification Deadline, either electronically or in writing;

8. Once a match is made between a program and an applicant, a binding commitment exists for the program to offer a training position to the applicant and for the applicant to accept such position;

9. The binding commitment requires programs to request a waiver or deferral from the NRMP should they determine they cannot train the matched applicant; and

10. All communications from the NRMP will be transmitted electronically to the email address provided by the institutional official at the time of registration, or through an update made by the program or institutional official, in the R3 system. Programs are solely responsible for the accuracy of their contact information. If a program unsubscribes from NRMP emails or notices, the NRMP has no responsibility for sending NRMP information or providing for its receipt.

## 5.0 REGISTRATION DATES AND MATCH FEES

### 5.1 Registration Dates

The annual registration and Match calendar are published annually on the NRMP website: www.nrmp.org.

### 5.2 Match Fees

Fees paid by programs and institutions are not refundable. Overpayments will be refunded upon request.

Fees will not be waived for institutions and programs that are activated for Match participation and subsequently withdrawn either by themselves or by the NRMP.

Each sponsoring institution must pay an institution registration fee, a program registration fee for each of its registered programs, and a matched applicant fee for each applicant with whom a program matches successfully. The NRMP will send an invoice to the institution for those fees, which must be paid within thirty (30) days of the invoice date. After the conclusion of a Match, an invoice for all incurred expenses, registration fees, and matched applicant fees will be issued by the NRMP to the institutional official, who will be responsible for ensuring prompt payment.

Institutions with unpaid NRMP fees at thirty (30) days from the date of the invoice will be issued a reminder request for payment. A late fee of 10 percent of the outstanding balance will be assessed on any fees unpaid sixty (60) days after the invoice date. Failure to remit payment to the NRMP after ninety (90) days from the invoice date will result in the institution being barred from registering any of its programs for the Main Residency Match or any SMS Fellowship Match until all fees are remitted by the institution to the NRMP.

## 6.0 PARTICIPATION IN THE MATCHING PROGRAM

The Matching Program process enables programs to investigate applicants and to make informed selection decisions based on the program's true preferences, on a uniform schedule, and without undue or unwarranted pressure.

### 6.1     Duty to Act in an Ethical and Professional Manner

All Match participants are required to conduct their affairs in an ethical and professionally responsible manner. The duty under this Agreement:

1. Extends throughout the application, interview, matching processes, and SOAP, if applicable; and

2. Through the 45th day following the start date of training as listed in the appointment contract; or

3. Upon conclusion of any NRMP-related waiver review, violation investigation, or appeal process.

NRMP's Codes of Conduct are available to review at www.nrmp.org.

### 6.2 Completeness, Timeliness, and Accuracy of Information

#### 6.2.1 Between the Program and Applicants

The NRMP is not responsible for ensuring the accuracy of information exchanged between programs and applicants. Programs are responsible for the completeness, timeliness, and accuracy of all information provided. This includes:

1. All written, electronic, and verbal information provided to applicants throughout recruitment, the onboarding cycle, and through the 45th day following the appointment start date; and

2. All written, electronic, and verbal information provided to the NRMP.

The omission of information pertinent to an applicant's decision to rank a program may be deemed a violation of this Agreement. Before the applicable Rank Order List Certification Deadline, or the offering of a position through SOAP in the Main Residency Match, the program shall:

1. Provide a copy of the appointment agreement that matched applicants will be expected to sign if such an agreement is available, or a copy of the agreement currently in use;

   o Once provided, applicants must be notified of any material change to the appointment agreement.

2. Provide all institutional and program policies regarding eligibility for appointment to a residency training position including but not limited to:

   o Expected or required academic, educational, or prior training credentials;

   o Pre-employment drug testing and background check;

   o Information relevant to licensure status, or visa status.

Programs shall obtain a signed acknowledgement of such communication from each applicant or be able to demonstrate that eligibility requirements were made available to each applicant.

The program's obligation to provide complete, timely, and accurate information extends through the applicant's 45th day following the start date as listed in the appointment agreement for the program position obtained through a Match or SOAP.

Programs must notify matched applicants and the NRMP of any circumstance (e.g., anticipated program closure, insufficient funding resulting in a reduction in training positions, etc.) that may delay, adversely impact, or prevent an applicant from commencing training with a matched program on the start date identified in the appointment agreement.

## 6.3    Confidentiality

Program information contained in the R3 system is confidential and available only to authorized users. Unauthorized use or disclosure of such information by an institution is a violation of this Agreement.

At all times, programs have the right to keep confidential:

1. All information pertaining to the names and identities of applicants;

2. All information pertaining to preference signals;

3. All information pertaining to offers, acceptance, and the outcomes of interviews; and

4. All information pertaining to ranking preferences and SOAP preferences

    o Rank order lists and SOAP preference lists are confidential, and it is the policy of the NRMP not to disclose such information in any manner that permits individual identification to other programs or applicants except in response to a subpoena or an order from a court of competent jurisdiction.

Before the applicable Rank Order List Certification Deadline:

1. A program may voluntarily communicate to an applicant that they are viewed favorably and will be ranked by the program; however, programs may not solicit verbal or written statements from an applicant implying a commitment to rank the program.

2. Applicants may voluntarily communicate their interest to a program(s); however, applicants may not solicit verbal or written statements from a program(s) implying a commitment to rank the applicant.

**6.4      Restrictions on Persuasion**

Programs have a right to make selection decisions that are free of undue or unwarranted pressure and should report to the NRMP any violations of these rights. Only the final preferences of programs and applicants as expressed on their final certified rank order list or by offers extended and accepted through SOAP for the Main Residency Match, will determine the offering of positions and placement of applicants through a Match.

Programs are not authorized at any time during the interview, matching, or onboarding processes to:

1. Request that applicants reveal the names, specialties, geographic locations, or other identifying information about the program(s) to which they have or may apply;

2. Request that applicants reveal preference signal(s) if in a specialty participating in preference signaling;

3. Request that applicants reveal any information pertaining to the interviews they were offered, accepted, declined, or attended;

4. Request that applicants reveal ranking preferences;

5. Suggest or inform applicants that placement on a rank order list or a SOAP preference list is contingent upon submission of a verbal, electronic, or written statement indicating the applicant's preference;

6. Make any written, electronic, or verbal offer or contract for appointment to a concurrent year residency or fellowship position before the release of the List of Unfilled Programs; and

7. Have any written, electronic, or verbal contact with a matched applicant not matched into their program for the purpose of offering an interview, offering placement in the program, or requesting the applicant apply to a program.

**6.5      Program Quota, Tracks, and Reversions**

It is the NRMP institutional official's responsibility to ensure that each program director checks the accuracy of quotas, reversions, and special requirements. This information is to be reviewed by the NRMP institutional official and any corrections or changes are to be communicated to the NRMP through the R3 system.

### 6.5.1   Quota

The program quota is the number of positions a program intends to fill through the Match.

1. In each Match year, programs are responsible for verifying their quota in the R3 system for each program and/or track before the

Quota Change Deadline. **Programs and/or tracks may not have a quota of zero.**

- o Programs may increase, decrease, or make other changes to the quota in the R3 system before the Quota Change Deadline in the R3 system. Quota changes must be approved by the institutional official.

2. Quota change requests made after the Quota Change Deadline must be in writing to [support@nrmp.org](mailto:support@nrmp.org), demonstrate substantial hardship, and be approved by the institutional official. Requests are subject to the NRMP's review and approval.

### 6.5.2   Program Tracks

Program tracks are identifiers within the R3 system that differentiate between program options within the same program and specialty. These include:

1. Position type (e.g., categorical versus preliminary positions; advanced positions);

2. Clinical and research options;

3. Campuses and geographic areas; and/or

4. Program focus (e.g., osteopathic recognition; rural)

When using tracks, programs must create a separate rank order list for each track; and place in each track the predetermined track quota. Track quotas cannot exceed the total quota for the program.

Programs may set up a reversion in the R3 system to guard against the position(s) being unfilled.

### 6.5.3   Program Reversions

Program reversions are the option to revert, or donate, unfilled positions in one program and/or track ("donor program") to another ("receiver program") in the event the program and/or track does not fill during the processing of the matching algorithm.

1. Any donor program may create a reversion in the R3 system, although reversions are typically formed between categorical and preliminary programs; traditional and primary care tracks; and clinical and research tracks;

2. Receiver programs must accept a designated number of unfilled positions from the donor program, but must not exceed the total approved positions for the program;

3. Reversions may be added, changed, or deleted in the R3 system at any time before the Rank Order List Certification Deadline;

4. All reversions must be approved by the institutional official by the Rank Order List Certification Deadline;

5. Donor programs may revert positions to multiple receiver programs either at the same institution or at a different institution; however, there may be no "circular reversions" in which two programs both donate and receive positions from each other.

6. Program tracks participating in a reversion must certify a rank order list.

   o Some programs elect to revert or donate their unfilled positions to two programs. For this type of reversion, the NRMP must know the exact sequence in which the unfilled positions are to be reverted. The sequence of reversions is entered in the R3 system.

   o The NRMP shall regularly monitor the compliance of Match-participating programs in registering and attempting to fill all eligible positions through the Match.

## 6.6 Linked and Restricted Programs

Program directors can link advanced programs to a designated preliminary program to limit enrollment in a preliminary program to that group of applicants who matched into a specific advanced program. Applicants should be told to rank the advanced program on their primary rank order lists and the preliminary program on the supplemental rank order list that corresponds to that advanced program. In addition, the preferred applicants must be ranked on the rank order lists of both the advanced program and the preliminary program.

During the matching process, the preliminary program will be considered only if the applicant matches to the advanced program and the preliminary program appears on a supplemental rank order list associated with the linked advanced program. Because of this restriction, the preliminary program will not appear in the *List of Unfilled Programs* of the NRMP Match results.

## 6.7. Withdrawal from the Match

Any registered program that will not offer positions through the Match must officially withdraw from that Match through the R3 system.

### 6.7.1 Withdrawal Before the Quota Change Deadline

The institutional official must confirm the program's withdrawal in the R3 system by the applicable Quota Change Deadline.

### 6.7.2 Withdrawal After the Quota Change Deadline

Programs demonstrating substantial hardship such as loss of funding or loss of accreditation may request to be withdrawn from the Match after the applicable Quota Change Deadline. In such cases, a written request must be co-signed by the institutional official and program director and submitted to the NRMP for determination of approval.

There may be no communication between fully matched applicants and programs for any reason until the general announcement of the Match results.

## 7.0 MATCHING AND APPOINTING RULES

### 7.1 Rank Order List Certification

To participate in a Match, programs must be registered for a Match and enter and certify their final rank order list in the R3 system before the applicable Rank Order List Certification Deadline. Certification of the rank order list will confirm the program's full participation in the Match and agreement to:

1. Adhere to the binding commitment to offer an appointment if a match result(s); and

2. Start training in good faith (i.e., with the intent to complete the applicant's training) on the date specified in the appointment agreement.

Before certifying the rank order list, programs shall:

1. Determine each applicant's eligibility by verifying the applicant's match status in the Applicant Match History available through the R3 system or by contacting NRMP support; and

2. Confirm the institution's willingness and/or ability to sponsor the visa type requested or intended by any non-U.S. citizen applicant ranked.

**The NRMP will not create or modify any program's rank order list.**

Programs may enter their rank order lists in more than one session and may modify their list multiple times before the Rank Order List Certification Deadline.

1. All entries or modifications to a rank order list require programs to certify or recertify the list before the Rank Order List Certification Deadline.

2. Program's whose rank order lists are not certified before the published deadline may, within 24 hours of receiving notification of an uncertified list, submit an electronic or written request and consent from the program director or institutional official to support@nrmp.org for NRMP to certify their list.

   o Requests received more than 24 hours after the notification of an uncertified list will not be processed by the NRMP.

o   Only the rank order lists displayed in the R3 system at the time of the Rank Order List Certification Deadline will be certified.

Once courtesy certification is complete, the NRMP will not uncertify the rank order list.

### 7.2 Communication about Appointments

Violations of any policies pertaining to communication between programs and applicants must be reported to the NRMP at policy@nrmp.org.

#### 7.2.1   Between the Rank Order List Certification Deadline and the notification of Match status

Programs shall refrain from discussing, interviewing for, or offering any position that would run concurrent with positions offered in a Match.

#### 7.2.2   Between the notification of Match status and the conclusion of Match Week:

There may be no communication between fully matched applicants and programs for any reason until the general announcement of the Match results.

## 8.0 MATCH WEEK SUPPLEMENTAL OFFER AND ACCEPTANCE PROGRAM (SOAP)

The Supplemental Offer and Acceptance Program ("SOAP") provides a uniform system for programs in the Main Residency Match to offer unfilled positions to eligible unmatched, or partially matched applicants through a series of offer rounds during Match Week. SOAP is not another Match.

Positions offered and accepted during SOAP constitute a binding commitment under this Agreement.

### 8.1     SOAP Participation

To participate in SOAP, programs:

1.  Must designate their SOAP status in the R3 system before the Quota Change Deadline;

    o   Programs failing to designate their participation in SOAP will be set to "No" in the R3 system and will not be eligible to participate in SOAP.

    o   Programs with the SOAP status designated as "No", cannot extend offers to applicants until SOAP concludes.

2.  Must have unfilled positions remaining after the matching algorithm has been processed;

3.  Agree to only consider SOAP-eligible applicants for unfilled positions until the conclusion of SOAP; and

4. Agree to offer unfilled positions only through the R3 system until the conclusion of SOAP.

At a time published on the NRMP website, eligible unfilled programs may:

1. Review applications from SOAP-eligible applicants through ERAS®;

2. Contact applicants of interest, interview applicants, and request additional information from applicants only after an application has been received; and

3. Express applicant preferences (i.e., make an offer) through a certified preference list only through the R3 system.

   o Preference lists must be submitted and/or updated before the deadline(s) as outlined on the published SOAP schedule.

At all times during SOAP, programs must provide accurate, complete, and timely information as outlined in this Agreement.

Until SOAP concludes, unfilled positions in all Match-participating programs shall be filled only through SOAP. Neither filled nor unfilled programs shall create positions for partially matched applicants until SOAP concludes.

### 8.2    SOAP Communication

Fully and partially unmatched SOAP-eligible applicants must submit applications or other materials pertaining to the application using the ERAS system.

Programs may not initiate or accept any verbal, written, or electronic communication from SOAP-eligible applicants nor their representatives until they have received that individual's application. Until and unless the program contacts the applicant or the applicant's representative, applicants may not initiate communication to the program.

SOAP-participating programs receiving communication from an applicant to whom they have not communicated must report the communication to policy@nrmp.org.

Directors of unfilled programs may communicate with each other but shall not initiate any contact with SOAP-eligible applicants before the published time and before receiving an individual's application.

Unmatched or partially matched applicants may contact unfilled programs freely at the conclusion of SOAP.

### 8.3    SOAP Applications and Process

At the times designated in the Match Week and SOAP calendar, programs may expect SOAP-eligible applicants to:

1. Access the *List of Unfilled Programs* only through the R3 system;

2.   Access, prepare, and send applications in the ERAS system;

3.   Begin receiving communications from SOAP-participating programs; and

4.   Receive offers through the R3 system.

   o   Applicants may ignore, accept, or reject program offers received. If the applicant does not accept an offer, they may continue to access the *List of Unfilled Programs*.

Upon conclusion of SOAP, unmatched and partially matched applicants:

1.   May access the *List of Unfilled Programs* in the R3 system;

2.   May contact all remaining unfilled programs; and

3.   May not seek to replace any matched position and/or position obtained through SOAP.

### 8.3.1     Exception - Unmatched SOAP-Eligible Applicants

Fully unmatched SOAP-eligible applicants who wish to refrain from participating in SOAP to pursue interests other than clinical residency training (e.g., research, Masters academic program, etc.) may do so in lieu of participating in SOAP provided:

1.   The position sought is not affiliated with a Match or SOAP-participating residency program;

2.   The position does not qualify for training credit in an ACGME-accredited residency program; and

3.   The applicant does not submit any applications to SOAP-participating programs during Match Week.

### 8.4     SOAP-Ineligible Applicants

Applicants' ineligible to enter graduate medical education on July 1 in the year of the Match will be considered SOAP-ineligible, may not participate in SOAP, and will not have access to the *List of Unfilled Programs* in the R3 system during SOAP.

Unmatched applicants who are SOAP-ineligible may not contact Match-participating programs until after SOAP concludes.

Unfilled programs may not initiate contact with any SOAP-ineligible applicants until after SOAP concludes.

### 8.5     List of Unfilled Programs

The *List of Unfilled Programs* will remain available to unmatched and partially matched applicants through 11:59 p.m. ET on May 1.

### 9.0    BINDING COMMITMENT

Upon conclusion of a Match and SOAP, programs:

1.  Are in a binding commitment with the applicant and must offer an appointment as matched or offered during SOAP and begin training in good faith on the date specified in the appointment contract:

    o   Programs who encourage an applicant with a Match or SOAP commitment to seek a concurrent year position, absent a waiver or deferral from the NRMP, shall be presumed to have violated the applicable Agreement.

2.  Must begin training applicants on the start date specified in the appointment contract with the intent to complete the applicant's training:

    o   The binding commitment will be deemed to have been honored by the applicant so long as the applicant enters and remains in the training program through the first 45 calendar days after the start date of the relevant appointment contract.

    o   The binding commitment exists through the first 45 calendar days of the start date of the relevant appointment contract.

    o   Programs terminating a resident within 45 days of the start date specified in the appointment agreement, without having an approved waiver or deferral from the NRMP, will be in violation of the applicable Agreement.

    o   Applicants who give notice of resignation, resign, or vacate a position within 45 days of the start date specified in the appointment agreement, without having an approved waiver or deferral from the NRMP, will be in violation of the applicable Agreement. Programs must report such violations to policy@nrmp.org.

Each appointment is subject to the official policies of the appointing institution and program in effect on the Rank Order List Certification Deadline or when the program submits its preference list if the program participates in SOAP for the Main Residency Match.

1.  Programs must adhere to the disclosure policies regarding accuracy, completeness, and timeliness of information as outlined in Section 6.2 of this Agreement.

2.  Programs who fail to disclose the official policies of the appointing institution and/or program, as outlined in Section 6.2 of this Agreement, prior to the Rank Order List Certification Deadline may not be eligible to receive a waiver or deferral of the matched appointment.

### 10.0 WAIVER OR DEFERRAL OF MATCH RESULTS

**Waiver:** The release of Match participants from the binding commitment following a Match.

**Deferral:** A one-year delayed start of training, mutually agreed to by the applicant and the program.

Neither applicants nor programs may release each other from a binding match commitment or a position offered and accepted during SOAP. A waiver or deferral of the binding commitment may be requested only from the NRMP. The NRMP has sole discretion to grant or deny a requested waiver or deferral. The terms of the Waiver and Deferral Policy are incorporated herein and binding upon all Match participants.

A waiver or deferral may be considered by the NRMP:

1. For circumstances demonstrating change of specialty or an unanticipated serious and extreme hardship; or

2. If NRMP determines the applicant is ineligible to begin training.

Programs considering a waiver or deferral request:

1. Shall review the Waiver and Deferral Policy on the NRMP website;

2. Shall submit the request in accordance with the directions provided on the NRMP website;

3. Shall demonstrate to the reasonable satisfaction of the NRMP that the criteria necessary for approval and issuance of a waiver or deferral are present;

4. Shall provide complete, timely, and accurate information to the NRMP in connection with its waiver or deferral review;

5. Shall not rescind an offer and/or agreement of training until the waiver or deferral request has been approved; and

6. Shall not accept applications, interview, or offer the position to another candidate until the waiver or deferral request has been approved.

Programs shall promptly notify the NRMP of waiver or deferral request(s) received from an applicant.

The NRMP's decision is final and is not subject to challenge in arbitration, by judicial review, or by review of a third party. The NRMP may grant a deferral of up to one year at the request of either a program or an applicant if arbitration proceedings have been initiated and the outcome is pending.

## 11.0   VACANT POSITIONS IN THE MAIN RESIDENCY MATCH

### 11.1    Categorical and Preliminary Positions

PGY-1 positions that become vacant due to an applicant dismissal, resignation, transfer, or approved waiver or deferral, may be filled outside of the Match provided training commences before February 1 of the year following the Match.

If training will not begin before February 1, the position shall be placed in the Match.

PGY-1 positions that become vacant any time after the conclusion of SOAP can be filled outside the Match prior to the day registration opens for the next Match.

### 11.2    Advanced Positions

PGY-2 positions in a specialty requiring a prerequisite PGY-1 year that become vacant before the Quota Change Deadline due to an applicant dismissal, resignation, transfer, or as the result of an approved waiver from the NRMP, may be filled outside the Match provided training begins before February 1.

If training will not begin before February 1, or if the position becomes vacant between the Quota Change Deadline and the Rank Order List Certification Deadline, the position shall be placed in the Match as a Reserved Position ("R") for a July start date.

If the position becomes vacant after the Rank Order List Certification Deadline, the position may be filled outside the Match at any time after the conclusion of SOAP and prior to the day registration opens for the next Match. After registration opens for the next Match, the vacant position must be placed in the Match.

## 12.0    VIOLATIONS

Institutions and its programs are expected to conduct their affairs in an ethical, professional, and responsible manner.

Institutions and its programs have a right to expect applicants and medical schools to also conduct their affairs in an ethical, professional, and responsible manner through throughout the application, interview and matching processes.

Known or suspected violations of any applicable Match Participation Agreement, by Match and SOAP participants, must be reported to the NRMP. Reports of a violation of Match and/or SOAP policy may be made anonymously.

### 12.1    Alleged Violations

At its discretion, NRMP will investigate alleged violations of this Agreement, including but not limited to:

1.  Failure to provide complete, timely, and accurate information during the application, interview, matching, and SOAP processes;

2.  Discrepancies in graduation credentials;

3. Attempts to subvert or circumvent eligibility requirements, the matching process, or SOAP;

4. Failure to offer or accept an appointment as required by the results of a Match outcome;

5. Failure to engage in ethical and/or professionally responsible behavior; or

6. 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 the Match outcome.

## 12.2    Violations Policy and Procedure

The NRMP Policies and Procedures for Reporting, Investigation, and Disposition of Violations of NRMP Agreements ("Violations Policy") may be found on the NRMP website and shall govern the handling of match violations. If the NRMP receives sufficient, credible information that a violation of the applicable Agreement may have occurred, the NRMP may initiate an investigation in accordance with the Violations Policy. Participants must provide complete, timely and accurate information to the NRMP in connection with its violation investigation. The terms of the Violations Policy (including, but not limited to, the consequences of a confirmed violation) are incorporated herein and binding upon all Match participants.

## 12.3    Withdrawal Due to Suspected Violation

**12.3.1  Authority:** The NRMP's authority to withdraw any Match participant from the Match under this section is in addition to its authority to impose sanctions for violations of this Agreement. At any time before the Match results are released, the NRMP may withdraw any participant from the Match or SOAP and without first affording an opportunity for a hearing if the NRMP believes it has credible evidence that:

1. The participant has violated the terms of this Agreement; and

2. Absent such summary withdrawal, the integrity of the Match is in jeopardy.

**12.3.2  Pending Action:** Upon withdrawal from the Match and/or SOAP due to an alleged violation, the participant's status in the R3 system will note "Pending Action," which will remain in effect until the participant has waived or exhausted all avenues of appeal as outlined in the NRMP Violations Policy.

A matched program(s) may not fill the applicant's position during the NRMP's investigation until the NRMP has issued a Final Report or granted a waiver, whichever is earlier.

If the violation investigation has not concluded by the start date of training, the program shall begin training the matched applicant unless NRMP has granted a waiver or issued a deferral to the next training year.

**12.3.3 Confirmed Violations:** If the NRMP's investigation of an alleged violation results in a finding that an institution has committed a violation of this Agreement, the institution may be identified in the R3 system as a Match violator to participating applicants and medical schools for one to three years or permanently, as determined by the NRMP.

If the NRMP's investigation of an alleged violation results in a finding that a program has committed a violation of the applicable Agreement, the program may be withdrawn from a Match and SOAP and sanctions levied as outlined in the Violations Policy.

## 13.0 PROGRAM CLOSURES AND REDUCTION IN COMPLEMENT OF MATCHED APPLICANTS

Programs closing or reducing the complement of matched applicants on or before the 45th day of training must notify the NRMP in writing of the method it will employ to assist each matched applicant in securing another graduate medical education position.

## 14.0 USE OF MATCH INFORMATION

### 14.1 Institution Use of Match Information

Institutions may use the R3 system and the information contained therein solely for the purpose of their participation in a Match and/or SOAP. Institutions and Match-participating programs may only share Match information from or maintained in the R3 system, including but not limited to, information from the *List of Unfilled Programs*, and/or *Regional Match Statistics by Specialty* internally with program leadership, program faculty, and program staff as required to participate in the Match and/or SOAP.

Institutional officials and their staff may not copy, distribute, post, or make publicly available in any other way, any Match information from or maintained in the R3 system, including information from the *List of Unfilled Programs*, and/or *Regional Match Statistics by Specialty*. URLs that link to information from the R3 system or PDFs that have been created, copied, or downloaded from the R3 system shall not be made public or redistributed in any form even if the information already is in the public domain.

Unauthorized disclosure of Match information by institutional officials and their staff is considered a violation of this Agreement and may result in sanctions to the program.

### 14.2 NRMP Use of Match Information

The NRMP releases individual applicant Match results to each program that ranked the applicant on its ROL and, in the case of any program participating in the SMS, to its specialty program director association's liaison to the NRMP, and to those program directors who request such information to verify whether the applicant was matched. The Match results of U.S. MD students and graduates, U.S. DO students and graduates, and Canadian students and graduates also are released to their respective schools of medicine or osteopathy.

The sponsoring institution acknowledges and agrees that the NRMP may request, obtain, transmit and receive identifying information (including information in the R3 system, individual applicant USMLE scores, COMLEX scores, Alpha Omega Alpha membership, and information regarding applicant volunteer and work experience) to and from authorized users, including the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the Association of American Medical Colleges, the American Medical Association, the Educational Commission for Foreign Medical Graduates, the Canadian Resident Matching Service, the National Board of Medical Examiners, the National Board of Osteopathic Medical Examiners, U.S. MD-granting medical schools, U.S. DO-granting medical schools, and other authorized users engaged in postgraduate medical education for purposes of

1. Collecting and verifying data submitted by the applicant or program;

2. Establishing postgraduate training databases;

3. Conducting a Matching Program;

4. Performing research; or

5. Effecting a Match.

**14.2.1 Ranking and Match Outcome Information:** For the avoidance of doubt, a rank order list submitted by a program is confidential, and the NRMP will not disclose or release program ranking information that is clearly and uniquely identifiable to any applicant or medical school except in response to a subpoena or an order from a court of competent jurisdiction. The NRMP may provide such identifiable information only to reputable organizations engaged in undergraduate, graduate or postgraduate education solely for the purposes of performing joint research under strict, binding terms of a confidential data sharing agreement. At no time will the NRMP allow program ranking and/or Match outcome information that is clearly and uniquely identifiable to be disclosed in publications, presentations, and reports resulting from such research.

The NRMP may anonymize and/or aggregate rank order list and/or Match outcome information and use it for its own research and reporting purposes and contribute such anonymized, aggregated information to national databases or for NRMP-approved research purposes.

## 15.0 REPRESENTATIONS AND WARRANTIES

Each sponsoring institution represents and warrants to the NRMP, on behalf of itself and all of its programs, that all of the information provided, or that will be provided, by such institution and each of its programs to the NRMP is at all times complete, timely, and accurate to the best of such institution's knowledge at the time such information was or will be provided. Each institutional official also represents that their unique log in information to access the R3 system will not be shared with or used by any other individual to access the system. Moreover, each institutional official represents that he/she has read, understood, and agrees to the NRMP's Privacy Policy, and represents that institutional personnel using and accessing NRMP information have read, understood, and will abide by the NRMP's Privacy Statement.

**16.0 DISCLAIMERS**

The parties acknowledge that the fees charged by the NRMP for participation in the Matching Program include no consideration for any assumption by the NRMP of the risk of any damages that may arise in connection with the participation of any institution's programs in the Matching Program or utilization of the R3 system.

Each party agrees that neither:

1.  the NRMP,

2.  any vendor providing equipment, software, or services to the NRMP ("Vendor"), nor

3.  any director, officer, employee, affiliate, or agent of the  NRMP, or any Vendor,

will be liable for any loss, damage, cost, or expense whatsoever, direct or indirect, regardless of the cause, that may arise out of, or be in any way related to this Agreement, the use of the Matching Program, the R3 system, or the automated systems and services utilized by the NRMP to implement the Matching Program or to send notices, including, but not limited to: (a) the suspension or termination of, or the inability to use, all or any part of the R3 system; (b) the erroneous transmission of any data or the transmission of any erroneous data; (c) any failure or delay suffered or allegedly suffered by any party in receiving or sending any rank order list or other information or in certifying a rank order list, however caused; (d) the delivery or transmission of any virus, worm, or other disruptive device; or (e) any other cause in connection with the furnishing of services or notices by the NRMP or the performance, maintenance, or use of, or inability to use, all or any part of the R3 system. The foregoing will apply regardless of whether a claim arises in contract, tort, negligence, strict liability, or otherwise.

The automated systems and services utilized by the NRMP to implement the Matching Program and the R3 system are provided "AS IS" and "AS AVAILABLE." **NONE OF THE NRMP, ANY VENDOR, OR ANY OF THEIR DIRECTORS, OFFICERS, AGENTS, EMPLOYEES, OR AFFILIATES MAKES ANY WARRANTY OR REPRESENTATION OF ANY KIND, EXPRESS OR IMPLIED, WITH RESPECT TO SUCH SERVICES, THE *R3* SYSTEM, OR THE MATCHING PROGRAM, OR TO THE ACCURACY, COMPLETENESS, SECURITY, TIMELINESS, OR RELIABILITY OF THE INFORMATION TO WHICH ANY PARTY HAS ACCESS OR TRANSMITS OR RECEIVES THROUGH THEM OR THROUGH ANY OTHER AUTOMATED SYSTEM. ALL IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, TITLE, AND NON-INFRINGEMENT ARE EXPRESSLY EXCLUDED.**

No oral or written information or advice given by the NRMP, any Vendor, or any of their directors, officers, agents, affiliates, or employees will create a warranty, and no party may rely on any such information or advice.  There is no assurance that the information the parties have access to through the R3 system will be accurate, complete, secure, timely, or reliable, or that the R3 system or the automated services utilized by the NRMP will be error-free or operate without interruption. In particular, and without limiting the generality of the foregoing, the NRMP makes no warranty that certified rank order lists processed through use of  such

automated services will be properly executed. Each program and applicant is solely responsible for verifying that the certified rank order list has been duly entered and certified.

## 17.0 LIMITATION OF LIABILITY

IN NO EVENT WILL THE NRMP, OR ANY VENDOR OR AFFILIATE BE LIABLE FOR ANY DAMAGES AS A RESULT OF ANY NEGLIGENT ACT OR OMISSION OF THE NRMP OR ANY VENDOR OR AFFILIATE, IRRESPECTIVE OF WHETHER THE INJURED PARTY IS AN INSTITUTION, A PROGRAM, OR A THIRD PARTY.

## 18.0 NOTICES

All notices to the NRMP must be given either by email at support@nrmp.org or through the R3 system and are effective upon receipt. The NRMP is not responsible for delays in email or Internet service. **Any notices or documents received by the NRMP after the relevant deadline date will not be considered.**

All notices to institutions or programs will be given either by (a) email to the email address provided by such party to the NRMP upon submission of such party's registration at the R3 system or (b) through the R3 system while the institution or program is logged on to the site. Such notices to institutions or programs given by email will be deemed given twenty-four (24) hours after sending, unless the sending party is notified that the email address is invalid or that the message was not delivered, or if the receiver has voluntarily unsubscribed from NRMP emails or notices. All notices given during an institution's or program's session on the R3 system will be deemed given at the time of such session.

## 19.0 DISPUTE RESOLUTION

Except for waiver determinations that are final when made by the NRMP and not subject to arbitration, judicial review, or review by any third party, as provided in this Agreement, all other disputes arising out of, or related to, the Matching Program, this Agreement, or the breach thereof, between or among the NRMP and any applicant or program participating, or seeking participation, in the Matching Program shall be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association then in effect (as modified below and excluding Procedures for Large, complex Disputes), unless the parties to the dispute mutually agree otherwise. The arbitration hearing shall commence within six months of filing the demand for arbitration or at another time agreeable to the NRMP. Notwithstanding the foregoing, no arbitrator shall have power to adjudicate any dispute as a class arbitration or as a consolidated arbitration without the express consent of  all the parties to any such dispute, and every arbitrator shall return a reasoned award in writing, setting forth the factual findings and legal conclusions that are the basis for the determination. In addition, no arbitrator shall have the power to modify any sanctions imposed by the NRMP unless (1) the arbitrator determines there is no basis in fact for a finding of violation; or (2) the arbitrator finds that the sanctions  imposed by the NRMP are either arbitrary and capricious or outside the scope of potential sanctions set forth in the applicable Match Participation Agreement and the Violations Policy.

Notice of the demand for arbitration must be filed in writing with all other parties to the arbitration and with the American Arbitration Association. A demand for arbitration in a matter that is covered by the Violations Policy must be made in accordance with the Violations Policy. The arbitrators must conduct all arbitration proceedings in the Office of the NRMP in

Washington, DC or at such other location in Washington, DC as mutually agreed upon by the parties. Each party will share equally in the cost of arbitration, except that the party requesting arbitration shall be solely responsible for paying the filing fee required by the AAA Standard Fee Schedule, including the Initial Filing Fee and the Case Service Fee, and the party requesting arbitration must further file the AAA form entitled "Demand for Arbitration – Commercial". The burden shall be on the applicant or program to demonstrate by clear and convincing evidence that an adverse decision by the NRMP was without basis-in-fact or in violation of the applicable Match Participation Agreement. The award by the arbitrator or arbitrators shall be final. Judgment upon the award rendered may be entered in any court having jurisdiction thereof, so long as the arbitrator(s) acted in good faith.  The arbitrator(s) may construe and interpret, but may not vary or ignore, the terms of the Agreement. The arbitrator(s) shall not have the power to make an award that is inconsistent with the provisions of this Agreement or with District of Columbia substantive law.

## 20.0 LIMITATION OF ACTION

No claim or cause of action, regardless of form, arising out of or related to the Matching Program, the Match Participation Agreement Among Applicants, the NRMP, and Participating Programs, or the breach thereof, this Agreement, or the breach thereof, or any other dispute between the NRMP and any applicant, program, or institution participating, or seeking participation, in the Matching Program, may be brought in any forum by any party more than 30 calendar days after the cause of action has accrued, regardless of any statute, law, regulation, or rule to the contrary ("Limitation Period"). The Limitation Period shall commence the day after the day on which the cause of action accrued. Failure to institute an arbitration proceeding within the Limitation Period will constitute an absolute bar and waiver of the institution of any proceedings, whether in arbitration, court, or otherwise, with respect to such cause of action. A cause of action that has become time-barred may not be exercised by way of counter claim or relied upon by way of exception.

In addition, any party who desires to contest a decision of a Review Panel of the NRMP must notify the NRMP in writing of its 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 within 30 calendar days of  receipt  of such report, in accordance with the terms  of the Violations Policy. If notice of a party's intent to seek arbitration is not received in writing 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 written demand for arbitration 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.

## 21.0 GENERAL

This Agreement is governed by the laws of the District of  Columbia, excluding its choice of laws provisions, and the agreed upon venue for any dispute arising from this Agreement is the District of Columbia.

The headings of the Sections of this Agreement have been inserted for convenience of reference only and shall in no way restrict or otherwise affect the construction of the terms or provisions of this Agreement. Unless indicated otherwise, references in this Agreement to Sections are to Sections of this Agreement.
If any provision of this Agreement is found in any arbitration proceeding or by any court of competent jurisdiction to be invalid, illegal, or unenforceable, that provision shall be modified  to

the minimum extent necessary to achieve the purpose originally intended, if possible, and the validity, legality, and enforceability of the remaining provisions will not be affected or impaired and are to be enforced to the maximum extent permitted by applicable law. If any remedy set forth in this Agreement is determined to have failed of its essential purpose, then all other provisions of this Agreement will remain in full force and effect.

Failure of any party to act or exercise its rights under this Agreement upon the breach of any other terms hereof by any other party is not to be construed as a waiver of such a breach or prevent such party from later enforcing compliance with any or all of the terms hereof. This Agreement contains the entire agreement between the parties with respect to the Matching Program and its results. Any representations, promises, or conditions not incorporated in this Agreement will not be binding upon any of the parties. No modification of this Agreement shall be effective unless in writing and executed by the party against whom it is to be enforced.