2025

OFFICIAL STUDY GUIDE

NATIONAL BOARD FOR CERTIFICATION
TRAINING ADMINISTRATORS OF GRADUATE MEDICAL EDUCATION

INITIAL EXAMINATION
MAINTENANCE OF CERTIFICATION EXAMINATION

ABOUT THIS GUIDE

This is the **official study guide** for the **National Board for Certification for Training Administrators of Graduate Medical Education (TAGME) Initial and Maintenance of Certification examinations**. It has been developed and approved by TAGME to support candidates in preparing for the certification examination.

Any other published materials, study resources, or preparatory guides that are not explicitly endorsed by TAGME should not be used as substitutes.

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Study Guide Navigation & Tips:

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TAGME

National Board for Certification

Training Administrators of Graduate Medical Education

ACGME Common Program Requirements (Residency)

Revision Information

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

ACGME-approved modification: September 30, 2024; effective July 1, 2025 - removed “or Canada” from 3.2.a. and 3.2.b.

Reformatted program requirements, effective July 1, 2025

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.

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ACGME Common Program Requirements (Residency)

Common Program Requirements (Residency) are in BOLD

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

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.

Definition of Specialty

[The Review Committee must further specify]

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Section 1: Oversight

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.

1.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

Participating Sites

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

1.2. 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]

1.3. 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)

1.3.a. The PLA must be renewed at least every 10 years. (Core)

1.3.b. The PLA must be approved by the designated institutional official (DIO). (Core)

1.4. The program must monitor the clinical learning and working environment at all participating sites. (Core)

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1.5. 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)

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 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**

1.6. 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]

1.7. 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)

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.

1.8. Resources
The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)

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[The Review Committee must further specify]

1.9. 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:

1.9.a. access to food while on duty; (Core)

1.9.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.

1.9.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 6.13.c.1.

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

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

1.10. 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)

1.11. 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]

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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.

Section 2: Personnel

2.1. Program Director
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)

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

2.2.a. 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. 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.

2.3. 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.

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2.4. 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 2.6. – 2.6.l. 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 2.2.a. 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 to fulfill their program responsibilities effectively.

2.5. Qualifications of the Program Director

The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)

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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.

2.5.a. The program director must possess 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. (Core)

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

2.5.b. The program director must demonstrate 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]

2.6. 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)

2.6.a. The program director must 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,

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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.

2.6.b. **The program director must 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.

2.6.c. **The program director must 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.

2.6.d. **The program director must 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.

2.6.e. **The program director must have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)**

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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.

2.6.f. **The program director must 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.

2.6.g. **The program director must 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)

2.6.h. **The program director must 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.

2.6.i. **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination.** (Core)

2.6.j. **The program director must document verification of education for all residents within 30 days of completion of or departure from the program.** (Core)

2.6.k. **The program director must provide verification of an individual resident's education upon the resident's request, within 30 days.** (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

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

2.6.l. The program director must 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]

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.

2.7. There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)

[The Review Committee may further specify]

2.8. Faculty Responsibilities
Faculty members must be role models of professionalism. (Core)

2.8.a. Faculty members must 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

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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.

2.8.b. **Faculty members must 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)

2.8.c. **Faculty members must administer and maintain an educational environment conducive to educating residents.** (Core)

2.8.d. **Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** (Core)

2.8.e. **Faculty members must 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.

2.8.e.1. **as educators and evaluators;** (Detail)

2.8.e.2. **in quality improvement, eliminating health inequities, and patient safety;** (Detail)

2.8.e.3. **in fostering their own and their residents' well-being; and,** (Detail)

2.8.e.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]

2.9. **Faculty Qualifications**

Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

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[The Review Committee may further specify]

2.10. Physician Faculty Members

Physician faculty members must 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]

2.11. 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.

2.11.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.]

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Background and Intent: If the Review Committee adds requirements as described in number (1) above, the Review Committee may choose to include background and intent as follows:

Background and Intent: Provision of support for the time required for the core faculty members' responsibilities related to resident education and/or administration of the program, as well as 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.

It is important to remember that the dedicated time and support requirement 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 core faculty members, is also addressed in Institutional Requirement 2.2.b. 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.

If the Review Committee adds requirements as described in number (2) above, the following Background and Intent must be included:

Background and Intent: The core faculty time requirements address the role and responsibilities of core faculty members, inclusive of both clinical and non-clinical activities, and the corresponding time to meet those responsibilities. The requirements do not address how this is accomplished, and do not mandate dedicated or protected time for these activities. Programs, in partnership with their Sponsoring Institutions, will determine how compliance with the requirements is achieved.

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

2.12. Program Coordinator
There must be a program coordinator. (Core)

2.12.a. 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.

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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 2.12.b. 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 2.2.d. 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 coordinators to fulfill their program responsibilities effectively.

2.13. 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]

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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.

Section 3: Resident Appointments

3.1. Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

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

3.2.a. graduation from a medical school in the United States, 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)

3.2.b. graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)

- **holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)**
- **holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)**

3.3. 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)

3.3.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)

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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.

[The Review Committee may further specify prerequisite postgraduate clinical education]

3.3.b. 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.]

3.3.b.1. An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in 3.2. – 3.3., but who does meet all of the following additional qualifications and conditions: (Core)

3.3.b.1.a. 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)

3.3.b.1.b. review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)

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

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

3.4. 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]

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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.

3.5. 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]

Section 4: 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.

4.1. Length of Program
[The Review Committee must further specify]

4.2. Educational Components
The curriculum must contain the following educational components:

4.2.a. 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)

4.2.b. 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)

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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.

4.2.c. 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.

4.2.d. a broad range of structured didactic activities; and, (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.

4.2.e. formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

ACGME Competencies

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.

The program must integrate all ACGME Competencies into the curriculum.

4.3. ACGME Competencies – Professionalism

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

Residents must demonstrate competence in:

4.3.a. compassion, integrity, and respect for others; (Core)

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4.3.b. **responsiveness to patient needs that supersedes self-interest; (Core)**

4.3.c. **cultural humility; (Core)**

4.3.d. **respect for patient privacy and autonomy; (Core)**

4.3.e. **accountability to patients, society, and the profession; (Core)**

4.3.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)**

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

4.3.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.

4.4. **ACGME Competencies – Patient Care**
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]

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.

4.5. **ACGME Competencies – Procedural Skills**
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]

4.6. **ACGME Competencies – 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]

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4.7. ACGME Competencies – 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)

4.7.a. Residents must demonstrate competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise. (Core)

4.7.b. Residents must demonstrate competence in setting learning and improvement goals. (Core)

4.7.c. Residents must demonstrate competence in identifying and performing appropriate learning activities. (Core)

4.7.d. Residents must demonstrate competence in 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)

4.7.e. Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice. (Core)

4.7.f. Residents must demonstrate competence in 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]

4.8. ACGME Competencies – 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)

4.8.a. Residents must demonstrate competence in 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)

4.8.b. Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-related agencies. (Core)

4.8.c. Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group. (Core)

4.8.d. Residents must demonstrate competence in educating patients, patients' families, students, other residents, and other health professionals. (Core)

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4.8.e. **Residents must demonstrate competence in acting in a consultative role to other physicians and health professionals.** (Core)

4.8.f. **Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable.** (Core)

4.8.g. **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]

4.9. ACGME Competencies – 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.

4.9.a. **Residents must demonstrate competence in working effectively in various health care delivery settings and systems relevant to their clinical specialty.** (Core)

4.9.b. **Residents must demonstrate competence in 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.

4.9.c. **Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems.** (Core)

4.9.d. **Residents must demonstrate competence in participating in identifying system errors and implementing potential systems solutions.** (Core)

4.9.e. **Residents must demonstrate competence in incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate.** (Core)

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4.9.f. **Residents must demonstrate competence in understanding health care finances and its impact on individual patients' health decisions.** (Core)

4.9.g. **Residents must demonstrate competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated).** (Detail)

4.9.h. **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]

4.10. Curriculum Organization and Resident Experiences – Curriculum Structure
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)

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.

[The Review Committee must further specify]

4.11. Curriculum Organization and Resident Experiences – Didactic and Clinical Experiences
Residents must be provided with protected time to participate in core didactic activities. (Core)

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

4.12. Curriculum Organization and Resident Experiences – Pain Management
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]

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

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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.

4.13. Program Responsibilities
The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

4.13.a. 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]

4.13.b. The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

4.14. Faculty Scholarly Activity
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**

4.14.a. The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

- **faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-**

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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)

- **peer-reviewed publication. (Outcome)**

[Review Committee will choose to require either the first bullet or both bullets under 4.14.a.]

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.

4.15. Resident Scholarly Activity
Residents must participate in scholarship. (Core)

[The Review Committee may further specify]

Section 5: Evaluation

5.1. Resident Evaluation: Feedback and Evaluation
Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)

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**

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- **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.

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.

5.1.a. **Evaluation must be documented at the completion of the assignment. (Core)**

5.1.a.1. **For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**

5.1.a.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)**

5.1.b. **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones. (Core)**

5.1.b.1. **The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)**

5.1.b.2. **The program must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)**

5.1.c. **The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones. (Core)**

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5.1.d. **The program director or their designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth. (Core)**

5.1.e. **The program director or their designee, with input from the Clinical Competency Committee, must 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.

5.1.f. **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)**

5.1.g. **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 5.1.a. - g.]

5.2. **Resident Evaluation: Final Evaluation**
The program director must provide a final evaluation for each resident upon completion of the program. (Core)

5.2.a. **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)**

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5.2.b. **The final evaluation must 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)

5.2.c. **The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.** (Core)

5.2.d. **The final evaluation must be shared with the resident upon completion of the program.** (Core)

5.3. **Clinical Competency Committee**

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

5.3.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)

5.3.b. **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)

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.

5.3.c. **The Clinical Competency Committee must review all resident evaluations at least semi-annually.** (Core)

5.3.d. **The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones.** (Core)

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5.3.e. **The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.** (Core)

5.4. Faculty Evaluation

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 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 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.

5.4.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)

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

5.4.c. **Faculty members must receive feedback on their evaluations at least annually.** (Core)

5.4.d. **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

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mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

5.5. Program Evaluation and Improvement
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)

5.5.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)

5.5.b. Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core)

5.5.c. Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)

5.5.d. Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)

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.

5.5.e. 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)

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**

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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**

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

5.5.g. **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)**

5.5.h. **The program must complete a Self-Study and submit it to the DIO. (Core)**

Board Certification

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, 5.6. – 5.6.f. will be omitted.]

5.6. **Board Certification**
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)

5.6.a. **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)**

5.6.b. **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)**

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5.6.c. **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)

5.6.d. **For each of the exams referenced in 5.6.a.-c., 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)

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 5.6.d. is designed to address this.

5.6.e. **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** (Core)

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.

Section 6: The Learning and Working Environment

The Learning and Working Environment

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

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- ***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***

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.

6.1. The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

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.

6.2. Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)

6.2.a. Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)

6.3. 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)

Quality Metrics

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

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

Supervision and Accountability

Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of

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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.

6.5. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. 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.

6.6. 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.]

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, 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.

Levels of Supervision

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

6.7. Direct Supervision

The supervising physician is physically present with the resident during the key portions of the patient interaction.

[The Review Committee may further specify]

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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 to eliminate this piece of the definition]

6.7.a. PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core)

[The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]

6.7.b. [The Review Committee may further specify]

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.

Oversight
The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

6.8. The program must define when physical presence of a supervising physician is required. (Core)

6.9. 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)

6.9.a. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)

6.9.b. 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)

6.9.c. 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)

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

6.10.a. 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.

6.11. 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)

6.12. Professionalism
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.

6.12.a. The learning objectives of the program must 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.

6.12.b. The learning objectives of the program must ensure manageable patient care responsibilities. (Core)

[The Review Committee may further specify]

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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.

6.12.c. **The learning objectives of the program must 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)

6.12.d. **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.

6.12.e. **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)

6.12.f. **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.

The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above will trigger a careful review and, if deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.

6.12.g. **Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional**

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behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

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.

6.13. The responsibility of the program, in partnership with the Sponsoring Institution, must include:

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

6.13.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.

6.13.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.

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6.13.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)

6.13.d. **education of residents and faculty members in:**

6.13.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)

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

6.13.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.

6.13.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.

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The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

6.14. 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)

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

6.14.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.

6.15. Fatigue Mitigation
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.

6.16. 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)

6.17. 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)

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[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.

6.18. 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.

6.19. Transitions of Care

Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

6.19.a. 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)

6.19.b. Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)

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.

6.20. Maximum Hours of Clinical and Educational Work per Week

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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.

6.21. Mandatory Time Free of Clinical Work and Education

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

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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.

6.21.a. 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.

6.21.b. 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."

6.22. Maximum Clinical Work and Education Period Length
Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

6.22.a. 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)

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Background and Intent: The additional time referenced in 6.22.a. 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.

6.23. Clinical and Educational Work Hour Exceptions
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)

6.23.a. 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.

6.24. 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.

6.24.a. 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.

6.25. Moonlighting

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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)

6.25.a. **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)

6.25.b. **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).

6.26. **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.]

6.27. **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)

6.28. **At-Home Call**
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)

6.28.a. **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 6.20. – 6.28.]

Background and Intent: As noted in 6.20., 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.

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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.

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ACGME Common Program Requirements (Fellowship)

Revision Information

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

Reformatted program requirements, effective July 1, 2025

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.

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ACGME Common Program Requirements (Fellowship)

Common Program Requirements (Fellowship) are in BOLD

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

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

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

Definition of Subspecialty
[The Review Committee must further specify]

Section 1: Oversight

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.

1.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

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

1.2. 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]

1.3. 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)

1.3.a. The PLA must be renewed at least every 10 years. (Core)

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1.3.b. The PLA must be approved by the designated institutional official (DIO). (Core)

1.4. The program must monitor the clinical learning and working environment at all participating sites. (Core)

1.5. 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)

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**

1.6. 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]

1.7. 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 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.

1.8. Resources

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]

1.9. 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:

1.9.a. access to food while on duty; (Core)

1.9.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.

1.9.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 6.13.c.1.

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

1.9.e. accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)

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1.10. **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)

1.11. **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)

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.

[The Review Committee may further specify]

Section 2: Personnel

2.1. **Program Director**
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)

2.2. **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)

2.2.a. **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. Requirement 2.2 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.

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2.3. 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 2.5. - 2.5.l. 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 to fulfill their program responsibilities effectively.

2.4. Qualifications of the Program Director:
The program director must possess subspecialty expertise and qualifications acceptable to the Review Committee. (Core)

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[The Review Committee may further specify]

2.4.a. **The program director must possess 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]

2.5. **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)

2.5.a. **The program director must 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 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.

2.5.b. **The program director must 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.

2.5.c. **The program director must 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.

2.5.d. **The program director must 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.

2.5.e. **The program director must 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.

2.5.f. **The program director must 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.

2.5.g. **The program director must 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)**

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2.5.h. **The program director must 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.

2.5.i. **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)**

2.5.j. **The program director must document verification of education for all fellows within 30 days of completion of or departure from the program. (Core)**

2.5.k. **The program director must provide verification of an individual fellow's education upon the fellow's request, within 30 days. (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 fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.

2.5.l. **The program director must 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]

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,

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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.

2.6. There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)

[The Review Committee may further specify]

2.7. Faculty Responsibilities
Faculty members must be role models of professionalism. (Core)

2.7.a. Faculty members must 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.

2.7.b. Faculty members must 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)

2.7.c. Faculty members must administer and maintain an educational environment conducive to educating fellows. (Core)

2.7.d. Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)

2.7.e. Faculty members must pursue faculty development designed to enhance their skills at least annually. (Core)

[The Review Committee may further specify regarding faculty development]

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

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specific to the institution or the program. Faculty development programming is to be reported for the fellowship program faculty in the aggregate.

[The Review Committee may further specify additional faculty responsibilities]

2.8. Faculty Qualifications
Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

[The Review Committee may further specify]

2.9. Subspecialty Physician Faculty Members
Subspecialty physician faculty members must 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]

2.9.a. 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]

2.10. 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)

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

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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.

2.10.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.]

Background and Intent: If the Review Committee adds requirements as described in number (1) above, the Review Committee may choose to include background and intent as follows:

Background and Intent: Provision of support for the time required for the core faculty members' responsibilities related to fellow education and/or administration of the program, as well as 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.

It is important to remember that the dedicated time and support requirement 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 core faculty members, is also addressed in Institutional Requirement 2.2.a. 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.

If the Review Committee adds requirements as described in number (2) above, the following Background and Intent must be included:

Background and Intent: The core faculty time requirements address the role and responsibilities of core faculty members, inclusive of both clinical and non-clinical activities, and the corresponding time to meet those responsibilities. The requirements do not address how this is accomplished, and do not mandate dedicated or protected

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time for these activities. Programs, in partnership with their Sponsoring Institutions, will determine how compliance with the requirements is achieved.

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

2.11. Program Coordinator
There must be a program coordinator. (Core)

2.11.a. 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 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.

The minimum required dedicated time and support specified in 2.11.b. 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

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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 2.2.d. 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 coordinators to fulfill their program responsibilities effectively.

2.12. 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)

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.

[The Review Committee may further specify]

Section 3: Fellow Appointments

3.1. Fellows must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

3.2. 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)

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3.2.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)

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.

[The Review Committee must further specify prerequisite postgraduate clinical education]

3.2.b. **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]

3.2.b.1. **An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in 3.2, but who does meet all of the following additional qualifications and conditions:** (Core)

3.2.b.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)

3.2.b.1.b. **review and approval of the applicant's exceptional qualifications by the GMEC; and,** (Core)

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3.2.b.1.c. **verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification.** (Core)

3.2.b.2. **Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation.** (Core)

[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 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.

3.3. **Fellow Complement**

The program director must not appoint more fellows than approved by the Review Committee. (Core)

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.

[The Review Committee may further specify minimum complement numbers]

3.4. **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]

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Section 4: 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.

4.1. Length of Program
[The Review Committee must further specify]

4.2. Educational Components
The curriculum must contain the following educational components:

4.2.a. 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)

4.2.b. 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)

4.2.c. 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.**

4.2.d. structured educational activities beyond direct patient care; and, (Core)

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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 4.10. – 4.12.

4.2.e. formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

ACGME Competencies

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.

The program must integrate all ACGME Competencies into the curriculum.

4.3. ACGME Competencies – Professionalism
Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

4.4. ACGME Competencies – Patient Care
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)

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.

[The Review Committee must further specify]

4.5. ACGME Competencies – Procedural Skills
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]

4.6. ACGME Competencies – Medical Knowledge

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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]

4.7. ACGME Competencies – 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)

4.8. ACGME Competencies – 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)

4.9. ACGME Competencies – 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)

4.10. Curriculum Organization and Fellow Experiences – Curriculum Structure
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]

4.11. Curriculum Organization and Fellow Experiences – Didactic and Clinical Experiences
Fellows must be provided with protected time to participate in core didactic activities. (Core)

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

4.12. Curriculum Organization and Fellow Experiences – Pain Management
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]

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

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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.

4.13. Program Responsibilities
The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)

[The Review Committee may further specify]

4.13.a. 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]

4.14. Faculty Scholarly Activity
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**

4.14.a. 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 4.14.a.1 or both 4.14.a.1 and 4.14.a.2]

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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.

4.14.a.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]

4.14.a.2. **peer-reviewed publication.** **(Outcome)**

[The Review Committee may further specify]

4.15. Fellow Scholarly Activity
[The Review Committee may further specify]

Independent Practice

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

4.16. **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

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the clinical and educational work hour limits. See Guide to the Common Program Requirements for more details.

Section 5: Evaluation

5.1. Fellow Evaluation: Feedback and Evaluation
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: 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.

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Fellows require feedback from faculty members

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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.

5.1.a. **Evaluation must be documented at the completion of the assignment. (Core)**

5.1.a.1. **For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**

5.1.a.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)**

5.1.b. **The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: (Core)**

5.1.b.1. **use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)**

5.1.b.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.

5.1.c. **The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each fellow their documented semi-annual evaluation of performance, including progress along the subspecialty-specific Milestones. (Core)**

5.1.d. **The program director or their designee, with input from the Clinical Competency Committee, must assist fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth. (Core)**

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5.1.e. **The program director or their designee, with input from the Clinical Competency Committee, must 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.

5.1.f. **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)

5.1.g. **The evaluations of a fellow's performance must be accessible for review by the fellow.** (Core)

[The Review Committee may further specify under any requirement in 5.1 – 5.1.g]

5.2. **Fellow Evaluation: Final Evaluation**
The program director must provide a final evaluation for each fellow upon completion of the program. (Core)

5.2.a. **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)

5.2.b. **The final evaluation must 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)

5.2.c. **The final evaluation must verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.** (Core)

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5.2.d. **The final evaluation must be shared with the fellow upon completion of the program.** (Core)

5.3. Clinical Competency Committee

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

5.3.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.

5.3.b. **The Clinical Competency Committee must review all fellow evaluations at least semi-annually.** (Core)

5.3.c. **The Clinical Competency Committee must determine each fellow's progress on achievement of the subspecialty-specific Milestones.** (Core)

5.3.d. **The Clinical Competency Committee must meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress.** (Core)

5.4. Faculty Evaluation

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

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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.

5.4.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)**

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

5.4.c. **Faculty members must receive feedback on their evaluations at least annually. (Core)**

5.4.d. **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.

5.5. **Program Evaluation and Improvement**
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)

5.5.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)**

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5.5.b. **Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them.** (Core)

5.5.c. **Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes.** (Core)

5.5.d. **Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** (Core)

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.

5.5.e. **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)

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**

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

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5.5.g. **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)

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

Board Certification

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, 5.6 – 5.6.f will be omitted.]

5.6. **Board Certification**
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)

5.6.a. **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)

5.6.b. **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)

5.6.c. **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)

5.6.d. **For each of the exams referenced in 5.6. – 5.6.c., 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)

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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 5.6.d. is designed to address this.

5.6.e. 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.

Section 6: The Learning and Working Environment

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***

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- ***Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team***

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.

6.1. The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

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.

6.2. Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)

6.2.a. Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)

6.3. 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)

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

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

[The Review Committee may further specify]

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

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes

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required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

6.5. Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. 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.

6.6. 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, 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.

Levels of Supervision

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

6.7. Direct Supervision

The supervising physician is physically present with the fellow during the key portions of the patient interaction.

[The Review Committee may further specify]

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 to eliminate this piece of the definition; The Review Committee may further specify]

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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.

Oversight
The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

6.8. The program must define when physical presence of a supervising physician is required. (Core)

6.9. 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)

6.9.a. The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. (Core)

6.9.b. 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)

6.9.c. 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)

6.10. Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)

6.10.a. 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)

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

6.11. 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)

6.12. Professionalism
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, 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.

6.12.a. The learning objectives of the program must 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.

6.12.b. The learning objectives of the program must ensure manageable patient care responsibilities. (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.

6.12.c. The learning objectives of the program must 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)

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6.12.d. **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.

6.12.e. **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)

6.12.f. **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.

The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above will trigger a careful review and, if deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.

6.12.g. **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)

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

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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.

6.13. The responsibility of the program, in partnership with the Sponsoring Institution, must include:

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

6.13.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.

6.13.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.

6.13.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)

6.13.d. education of fellows and faculty members in:

6.13.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)

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

6.13.d.3. access to appropriate tools for self-screening. (Core)

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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.

6.13.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.

6.14. **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)**

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

6.14.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)**

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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.

6.15. Fatigue Mitigation

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.

6.16. 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)

6.17. 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.

6.18. Teamwork

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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.

6.19. Transitions of Care

Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

6.19.a. 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)

6.19.b. Programs must ensure that fellows are competent in communicating with team members in the hand-off process. (Outcome)

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.

6.20. 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

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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.

6.21. Mandatory Time Free of Clinical Work and Education
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.

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6.21.a. **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.

6.21.b. **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."

6.22. **Maximum Clinical Work and Education Period Length**
Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

6.22.a. **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 6.22.a. 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.

6.23. **Clinical and Educational Work Hour Exceptions**
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

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patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)

6.23.a. **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.

6.24. **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.**

6.24.a. **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.

6.25. **Moonlighting**

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)

6.25.a. **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).

6.26. **In-House Night Float**

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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.]

6.27. 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)

6.28. At-Home Call
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)

6.28.a. 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 6.20. – 6.28.a.]

Background and Intent: As noted in 6.20., 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.

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ACGME Institutional Requirements

Revision Information

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

Reformatted program requirements, effective July 1, 2025

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.

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ACGME Institutional Requirements

Section 1: Structure for Educational Oversight

1.1. Sponsoring Institution
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)

1.1.a. 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)

1.1.b. 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)

1.1.c. 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)

1.2. The Sponsoring Institution must identify a designated institutional official (DIO). (Core)

1.2.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)

1.2.b. The DIO must 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)

1.2.c. The DIO must oversee submissions of the Annual Update for each program and the Sponsoring Institution to the ACGME. (Core)

1.2.d. The DIO must 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)

1.3. 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)

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1.4. 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:

1.4.a. GME mission; and, (Core)

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

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

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

1.6.a. Accreditation for patient care must be provided by:

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

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

1.7. 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)

1.8. 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)

1.9. Graduate Medical Education Committee (GMEC) Membership

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

1.9.a.1. the DIO; (Core)

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

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

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1.9.a.4. a quality improvement or patient safety officer or designee. (Core)

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

1.9.b.1. the DIO; (Core)

1.9.b.2. the program director when the program director is not the DIO; (Core)

1.9.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)

1.9.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)

1.9.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)

1.9.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)

1.10. 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)

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

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

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

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

1.12. Responsibilities
GMEC responsibilities must include oversight of:

1.12.a. ACGME accreditation and recognition statuses of the Sponsoring Institution and each of its ACGME-accredited programs; (Outcome)

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1.12.b. the quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites; (Outcome)

1.12.c. 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)

1.12.d. the ACGME-accredited program(s)' annual program evaluation(s) and Self-Study(ies); (Core)

1.12.e. 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)

1.12.f. all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution; and, (Core)

1.12.g. 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)

1.13. GMEC responsibilities must include review and approval of:

1.13.a. institutional GME policies and procedures; (Core)

1.13.b. GMEC subcommittee actions that address required GMEC responsibilities; (Core)

1.13.c. annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits; (Core)

1.13.d. applications for ACGME accreditation of new programs; (Core)

1.13.e. requests for permanent changes in resident/fellow complement; (Core)

1.13.f. 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)

1.13.g. additions and deletions of each of its ACGME-accredited programs' participating sites; (Core)

1.13.h. appointment of new program directors; (Core)

1.13.i. progress reports requested by a Review Committee; (Core)

1.13.j. responses to Clinical Learning Environment Review (CLER) reports; (Core)

1.13.k. requests for exceptions to clinical and educational work hour requirements; (Core)

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1.13.l. voluntary withdrawal of ACGME program accreditation or recognition; (Core)

1.13.m. requests for appeal of an adverse action by a Review Committee; (Core)

1.13.n. appeal presentations to an ACGME Appeals Panel; and, (Core)

1.13.o. 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)

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

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

1.14.a.1. the most recent ACGME institutional letter of notification; (Core)

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

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

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

1.14.b.1. The written executive summary must include a summary of institutional performance on indicators for the AIR. (Core)

1.14.b.2. The written executive summary must include action plans and performance monitoring procedures resulting from the AIR. (Core)

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

1.15.a. The Special Review process must include a protocol that: (Core)

1.15.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)

1.15.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)

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Section 2: Institutional Resources

2.1. Institutional GME Infrastructure and Operations
The Sponsoring Institution must ensure that the DIO has sufficient support and dedicated time to effectively carry out educational, administrative, and leadership responsibilities. (Core)

2.1.a. The Sponsoring Institution must ensure that the DIO engages in professional development applicable to responsibilities as an educational leader. (Core)

2.1.b. The Sponsoring Institution must ensure that sufficient salary support and resources are provided for effective GME administration. (Core)

2.2. 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:

2.2.a. 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)

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

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

2.2.d. support and time for the program coordinator(s) to effectively carry out responsibilities; and, (Core)

2.2.e. resources, including space, technology, and supplies, to provide effective support for each of its ACGME-accredited programs. (Core)

2.3. 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)

2.3.a. 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)

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2.3.b. Residents/fellows must have the option, at least in part, to conduct their forum without the DIO, faculty members, or other administrators present. (Core)

2.3.c. Residents/fellows must have the option to present concerns that arise from discussions at the forum to the DIO and GMEC. (Core)

2.4. 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)

2.5. Educational Tools

Communication resources and technology: Faculty members and residents/fellows must have ready access to adequate communication resources and technological support. (Core)

2.5.a. 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)

2.6. Support Services and Systems

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. (Core)

2.6.a. These support services and systems must include 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)

2.6.b. These support services and systems must include medical records available at all participating sites to support high quality and safe patient care, residents'/fellows' education, quality improvement and scholarly activities. (Core)

2.6.c. These support services and systems must include 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)

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Section 3: The Learning and Working Environment

3.1. 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)

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

3.2.a. Patient Safety
The Sponsoring Institution must ensure that residents/fellows have access to systems for reporting errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal. (Core)

3.2.a.1. The Sponsoring Institution must ensure that residents/fellows have opportunities to contribute to root cause analysis or other similar risk-reduction processes. (Core)

3.2.b. Quality Improvement
The Sponsoring Institution must ensure that residents/fellows have access to data to improve systems of care, reduce health care disparities, and improve patient outcomes. (Core)

3.2.b.1. The Sponsoring Institution must ensure that residents/fellows have opportunities to participate in quality improvement initiatives. (Core)

3.2.c. Transitions of Care
The Sponsoring Institution must facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care. (Core)

3.2.c.1. The Sponsoring Institution must 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)

3.2.d. Supervision and Accountability
The Sponsoring Institution must oversee supervision of residents/fellows consistent with institutional and program-specific policies. (Core)

3.2.d.1. The Sponsoring Institution must oversee mechanisms by which residents/fellows can report inadequate supervision and accountability in a protected manner that is free from reprisal. (Core)

3.2.e. Clinical Experience and Education
The Sponsoring Institution must oversee resident/fellow clinical and educational work hours, consistent with the Common and specialty-/subspecialty-specific

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Program Requirements across all programs, addressing areas of non-compliance in a timely manner. (Core)

3.2.e.1. The Sponsoring Institution must oversee systems of care and learning and working environments that facilitate fatigue mitigation for residents/fellows. (Core)

3.2.e.2. The Sponsoring Institution must oversee an educational program for residents/fellows and faculty members in fatigue mitigation. (Core)

3.2.f. Professionalism

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)

3.2.f.1. 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)

3.2.f.2. The Sponsoring Institution must provide systems for education in and monitoring of residents'/fellows' and core faculty members' fulfillment of educational and professional responsibilities, including scholarly pursuits. (Core)

3.2.f.3. The Sponsoring Institution must provide systems for education in and monitoring of accurate completion of required documentation by residents/fellows. (Core)

3.2.f.4. 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)

3.2.f.4.a. 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)

3.2.g. Well-Being

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)

3.2.g.1. The Sponsoring Institution, in partnership with its ACGME-accredited program(s), must educate faculty members and residents/fellows in

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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)

3.2.g.2. The Sponsoring Institution, in partnership with its ACGME-accredited program(s), must 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)

3.2.g.3. The Sponsoring Institution, in partnership with its ACGME-accredited program(s), must provide access to appropriate tools for self screening. (Core)

3.2.g.4. The Sponsoring Institution, in partnership with its ACGME-accredited program(s), must 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)

3.2.g.5. The Sponsoring Institution must ensure a healthy and safe clinical and educational environment that provides for: (Core)

3.2.g.5.a. access to food during clinical and educational assignments; (Core)

3.2.g.5.b. 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)

3.2.g.5.c. safe transportation options for residents/fellows who may be too fatigued to safely return home on their own; (Core)

3.2.g.5.d. 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)

3.2.g.5.e. safety and security measures appropriate to the clinical learning environment site; and, (Core)

3.2.g.5.f. accommodations for residents/fellows with disabilities, consistent with the Sponsoring Institution's policy. (Core)

3.2.g.6. 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)

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Section 4: Institutional GME Policies and Procedures

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

4.2. Resident/Fellow Appointments
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)

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

4.2.a.1. graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or, (Core)

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

4.2.a.3. graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core)

- holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or, (Core)
- 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)

4.2.b. 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)

4.2.b.1. Information that is provided must include stipends, benefits, professional liability coverage, and disability insurance accessible to residents/fellows. (Core)

4.2.b.2. Information that is provided must include institutional policy(ies) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence. (Core)

4.2.b.3. Information that is provided must include health insurance accessible to residents/fellows and their eligible dependents. (Core)

4.3. Agreement of Appointment/Contract
The Sponsoring Institution must ensure that residents/fellows are provided with a written agreement of appointment/contract outlining the terms and conditions of their

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appointment to a program. The Sponsoring Institution must monitor each of its programs with regard to implementation of terms and conditions of appointment. (Core)

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

4.3.a.1. resident/fellow responsibilities; (Core)

4.3.a.2. duration of appointment; (Core)

4.3.a.3. financial support for residents/fellows; (Core)

4.3.a.4. conditions for reappointment and promotion to a subsequent PGY level; (Core)

4.3.a.5. grievance and due process; (Core)

4.3.a.6. professional liability insurance, including a summary of pertinent information regarding coverage; (Core)

4.3.a.7. health insurance benefits for residents/fellows and their eligible dependents; (Core)

4.3.a.8. disability insurance for residents/fellows; (Core)

4.3.a.9. vacation and leave(s) of absence for residents/fellows, including medical, parental, and caregiver leave(s) of absence, and compliant with applicable laws; (Core)

4.3.a.10. timely notice of the effect of leave(s) of absence on the ability of residents/fellows to satisfy requirements for program completion; (Core)

4.3.a.11. information related to eligibility for specialty board examinations; and, (Core)

4.3.a.12. institutional policies and procedures regarding resident/fellow clinical and educational work hours and moonlighting. (Core)

4.4. Promotion, Appointment Renewal and Dismissal

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)

4.4.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)

4.4.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)

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4.5. 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)

4.6. Professional Liability Insurance

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)

4.6.a. The Sponsoring Institution must ensure that residents/fellows are provided with official documentation of the details of their professional liability coverage before the start date of resident/fellow appointments. (Core)

4.6.b. The Sponsoring Institution must ensure that residents/fellows are provided with written advance notice of any substantial change to the details of their professional liability coverage. (Core)

4.7. Health and Disability Insurance

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)

4.7.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)

4.7.b. 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)

4.7.b.1. 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)

4.8. Vacation and Leaves of Absence

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

4.8.a. This policy must 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)

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4.8.b. This policy must 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)

4.8.c. This policy must 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)

4.8.d. This policy must 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)

4.8.e. This policy must describe the process for submitting and approving requests for leaves of absence. (Core)

4.8.f. This policy must be available for review by residents/fellows at all times. (Core)

4.8.g. This policy must ensure that each of its ACGME-accredited programs provides its residents/fellows with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's/fellow's eligibility to participate in examinations by the relevant certifying board(s). (Core)

4.9. Resident Services

4.9.a. Behavioral Health
The Sponsoring Institution must ensure that residents/fellows are provided with access to confidential counseling and behavioral health services. (Core)

4.9.b. Physician Impairment
The Sponsoring Institution must have a policy, not necessarily GME-specific, which addresses physician impairment. (Core)

4.9.c. 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)

4.9.d. 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)

4.9.e. 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)

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4.10. Supervision
The Sponsoring Institution must maintain an institutional policy regarding supervision of residents/fellows. (Core)

4.10.a. 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)

4.11. 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)

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

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

4.11.a.2. residents/fellows must have written permission from their program director to moonlight; (Core)

4.11.a.3. 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)

4.11.a.4. the Sponsoring Institution or individual ACGME-accredited programs may prohibit moonlighting by residents/fellows. (Core)

4.12. 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)

4.13. 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)

4.14. 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)

4.14.a. This policy must include information about assistance for continuation of salary, benefits, professional liability coverage, and resident/fellow assignments. (Core)

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4.15. 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)

4.15.a. 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)

4.15.b. 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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Frequently Asked Questions:
2024-2025 ACGME Accreditation Data System (ADS) Annual Update

An overview of the ADS Annual Update for domestic programs is available here. Email questions about the 2024-2025 ADS Annual Update to accreditation@acgme.org or ADS@acgme.org.

Sponsoring Institution-Specific Questions

1. How can a Sponsoring Institution set the Annual Update to be the same for all its accredited programs regardless of whether they use Case Logs?
   Answer: Sponsoring Institutions have the option to set the same ADS Annual Update for all their programs. To make that request, the DIO should email ADS@acgme.org.

2. If a program director is also the DIO, can the duplicate approval be removed for the ADS Annual Update?
   Answer: No. The DIO must oversee programs' Annual Update submissions even when the same individual serves as a program director.

3. What happens if the DIO does not approve the ADS Annual Update or if requested edits are not made?
   Answer: The ACGME's ADS team will make several attempts to follow up with programs that do not submit their ADS Annual Update by the due date. Information concerning ADS Annual Update approvals may be provided to the Institutional Review Committee and specialty Review Committees for use in accreditation processes. As part of their oversight responsibilities, the DIO and/or Graduate Medical Education Committee (GMEC) should follow up with programs that do not respond to feedback regarding the ADS Annual Update.

4. Could there be two different ADS Annual Update deadlines – one for programs to submit to the DIO, and a different deadline for DIOs to submit to the ACGME, especially for large institutions?
   Answer: This is not currently under consideration. DIOs and program directors should plan ahead to ensure timely review of their programs' ADS Annual Updates. DIOs may set additional expectations for program submission timelines in advance of the ACGME deadline. ADS Annual Update questions are available after the ADS rollover (June 29 for 2024), which allows programs time to begin developing responses in advance of the ADS Annual Update window opening date.

Program-Specific Questions

1. What is the ADS rollover and what occurs during those dates?
   Answer: The ADS academic year rollover is a term used to describe the transition of ADS from one academic year to the following academic year (e.g., the transition from 2023-2024 to 2024-2025). An announcement is posted on the ADS login page that specifies the date of the rollover (June 29 for 2024). When the rollover occurs, data in ADS collected for the current academic year is archived, the screens in ADS will reflect the new academic year, and all residents/fellows are given an "unconfirmed" status.

2. Can the ACGME provide a report listing which programs are Case Log specialties?
   Answer: A detailed list of all specialties and their ADS Annual Update window is available in the ACGME's ADS Help Center .

3. Do the changes to the 2024-2025 ADS Annual Update apply to ACGME-I-accredited programs?

Answer: The ADS Annual Update for ACGME International (ACGME-I)-accredited programs is different and international programs should email acgme-i@acgme-i.org for more information.

4. Are there parts of the ADS Annual Update that can be completed before the window opens?
Answer: No. All areas of ADS can be updated after the rollover date for the new academic year (June 29 for 2024). The ADS Annual Update window dates provide a period during which programs must update ADS.

5. Should applications be updated during the ADS Annual Update?
Answer: Applications for program accreditation submitted prior to the academic year rollover (June 29, 2024) and not yet accredited will not be assigned to complete the ADS Annual Update. Applications in progress and not yet submitted at the time of the academic year rollover will be prompted to update responses to the application questions only if changes have been made as part of the ADS Annual Update to any questions within an application. Once the program achieves Initial Accreditation, it will be scheduled for the next ADS Annual Update. If the program's accreditation is withheld, the program may proceed with re-application.

6. If a program just received Initial Accreditation, does it need to complete the ADS Annual Update?
Answer: The ADS Annual Update is assigned by the ACGME based on program accreditation status as of July 1, 2024, and programs with Initial Accreditation as of that date will be assigned to complete the 2024-2025 ADS Annual Update.

7. If a program with Initial Accreditation has had an accreditation site visit but hasn't received results, does the program need to complete the ADS Annual Update?
Answer: The timing between when an accreditation site visit occurs and when a Review Committee reviews the Site Visit Report and issues an accreditation decision may be several months. Programs will be assigned the ADS Annual Update questions that apply to their accreditation status as of July 1, 2024.

8. Do programs with Initial Accreditation without residents/fellows have to complete the ADS Annual Update?
Answer: Yes. All programs with Initial Accreditation and Initial Accreditation with Warning must review and complete all items under "Annual Update" on the Overview tab. They do NOT need to update documents under "Updated Application" on the Overview tab.

9. Are the ADS Annual Update questions different for programs with Continued Accreditation without Outcomes?
Answer: The same ADS Annual Update questions apply to programs with Continued Accreditation, Continued Accreditation without Outcomes, Continued Accreditation with Warning, and Probation.

10. If a program recently achieved Continued Accreditation, what should it do if it hasn't received citations by the start of the ADS Annual Update window?
Answer: If a program has no citations, it will not need to respond to citations as part of the ADS Annual Update. If a program was reviewed as part of the 2023-2024 annual program review, it will be issued an accreditation decision and a Letter of Notification (LoN) before June 30, 2024. A response to any citations included in the LoN, if applicable, will be required during the ADS Annual Update.

11. If a program is closing on June 30, 2024, will it be assigned the 2024-2025 ADS Annual Update?
Answer: If a program has submitted a Voluntary Withdrawal request in ADS and the request has been approved by the specialty Review Committee, or if the program had its accreditation

withdrawn by a Review Committee effective June 30, 2024, it will not be assigned to complete the 2024-2025 ADS Annual Update.

Osteopathic Recognition ADS Annual Update

1. How does a program know if it has Osteopathic Recognition?
   Answer: Osteopathic Recognition is a designation conferred by the ACGME's Osteopathic Recognition Committee on ACGME-accredited programs that demonstrate, through a formal application process, the commitment to teaching and assessing Osteopathic Principles and Practice (OPP) at the graduate medical education level. More information is available on the ACGME website in the Osteopathic Recognition web page. If a program has Osteopathic Recognition, a recognition status will appear in ADS on the Program tab in the same box as the program's current accreditation status.

2. Are programs with Osteopathic Recognition required to update recognition-related information during the ADS Annual Update?
   Answer: Programs with Osteopathic Recognition are responsible for reviewing and updating recognition-related information provided in ADS during the program's assigned ADS Annual Update window to ensure it is up to date and accurate. The **ADS Annual Update Guide for Osteopathic Recognition**, available in the **Announcements** section of the Osteopathic Recognition web page on the ACGME website, specifies the information that programs with Osteopathic Recognition must review and update during their assigned ADS Annual Update window.

Common Program Requirements Questions

1. How does the US Supreme Court decision restricting the use of race in college admissions impact how programs should answer the following ACGME Annual Update question: "Describe what the program will be/is doing to achieve/ensure diversity in resident/fellow recruitment and retention."?
   Answer: The US Supreme Court decisions in *Students for Fair Admission v. Harvard College and the University of North Carolina* address the Equal Protection Clause and Title VI of the Civil Rights Act of 1964, which prohibit race-based discrimination by institutions that receive federal funding, and the case focused on higher education admissions policies. Over the years, federal court cases addressing resident/fellow physicians have been decided under Title VII of the same Act, which applies to employers broadly. Title VII prohibits race-based discrimination in the employment context. Therefore, the short answer to the question is that programs should not need to do anything differently than they have previously with respect to resident/fellow recruitment/hiring, assuming their practices are consistent with Title VII.

   This Annual Update question relates to ACGME Common Program Requirement I.C., which states that programs 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." The ACGME has reaffirmed its commitment to this requirement (See ACGME President and Chief Executive Officer Dr. Thomas J. Nasca's June 13, 2023 Letter to the Graduate Medical Education Community in the ACGME Newsroom as a way to help eliminate health care inequities and disparities, to support graduate medical education and training that improve residents'/fellows' skills in patient care, to assist Sponsoring Institutions and programs in

achievement of their missions, and to develop a diverse physician workforce to provide care that meets the needs of marginalized patients in particular, and all patients in general.

It is important to note that the ACGME does not require race-based affirmative action to achieve diversity. There are numerous strategies and tools available, consistent with existing law, that can be utilized in institutions' achievement of their mission-oriented workforce plans. Some of these alternative strategies can be found in the ACGME Equity Matters Equity Practice ACGME Equity Matters Holistic Admissions Toolkit available in the ACGME's distance learning portal, Learn at ACGME. The ACGME is also working on development of the *ACGME Equity Matters®* Resource Collection, a compilation of real-world examples of approaches to advance diversity, equity, and inclusion (DEI) practices in GME programs. The collection will include more than 100 approaches, organized into six categories (Pathway Initiatives, Resident Recruitment, Resident Retention, Faculty Recruitment, Faculty Retention, and Personnel Practices) that have been used to achieve diversity in the physician workforce and to make the learning environment more inclusive. To reinforce the importance of responding to this question, recognize that diversity does not only include race/ethnicity but also includes gender orientation, age, religion, nationality, and language.

2. What is expected as far as a description in the ADS Annual Update for what a program will be/is doing to achieve/ensure diversity in the recruitment and retention of residents/fellows and individuals participating in the program?
Answer: Programs are encouraged to describe in detail any specific efforts to advance the diversity of residents/fellows and other individuals participating in the program (e.g., faculty members and administrative personnel), consistent with existing law. The ACGME recognizes that inclusion and equity within the learning environment are essential in supporting this outcome. Evidence-based strategies and success stories illustrating these efforts are strongly recommended. Examples should include affiliated medical schools or Sponsoring Institutions' efforts only if they are done in partnership with the program. This is an opportunity to describe practices instituted in the program to result in recruitment and retention of diverse individuals. Do not simply copy and paste general diversity policies and statements of the institution. Any numerical data supporting the success of these diversity efforts (e.g., number of students involved, success of students after participation) should be included whenever possible. The goal is that programs will outline the concrete steps they are taking to foster diversity among early learners, residents/fellows, and other individuals participating in the program rather than broad, philosophical policies. They should describe strategies to achieve inclusion within the learning environment because this supports the type of circumstances in which diversity thrives.

3. In the ADS Annual Update, what numerical data should programs provide to demonstrate the success of efforts to achieve diversity in the recruitment and retention of residents/fellows and individuals participating in the program?
Answer: The language asking programs to quantify efforts to increase the diversity of residents/fellows and individuals participating in the program is intended to provide a baseline to determine the effectiveness of such measures in the future. ACGME Common Program Requirement I.C. focuses on ongoing, systematic recruitment and retention of a diverse workforce. Programs are encouraged to continue recruiting diverse classes as they currently do, consistent with existing law. The requirement encourages programs and institutions to engage learners earlier and further upstream in the career pathway to provide equal opportunities, such as developing programs for early medical students that introduce specialties; providing research, mentoring, and shadowing opportunities for college and post-baccalaureate students; and/or partnering with local science, technology, engineering, and mathematics (STEM) programs to encourage biomedical careers for high school and elementary students. For programs with such efforts already in place, the request for numerical impact will provide a baseline to track progress.

Numerical data that support the success of these efforts can include measures of practical outcomes, numbers of participants in an activity or approach, and any metrics that can be determined to measure efforts in achieving diversity in the recruitment and retention of residents/fellows and others participating in the program, consistent with existing law. Do not feel compelled to provide the number of residents/fellows in the program by demographic category since this information is already collected through other parts of the Annual Update. Numerical data on faculty members and other academic individuals could be included in response to the question regarding efforts to increase diversity through faculty recruitment and retention, as this information is not collected elsewhere in the Annual Update.

4. Should programs proactively address areas of concern in the Resident/Fellow or Faculty Survey in the ADS Annual Update?
   Answer: Programs are strongly encouraged to address both Resident/Fellow and Faculty Survey areas of concern in the "Major Changes and Other Updates" section of ADS during the ADS Annual Update.

5. Are there questions about dedicated time for the program coordinator and program director?
   Answer: The ADS Annual Update includes questions about dedicated time for the program coordinator and program director, as well as associate program directors, as applicable. This information will also be verified by Accreditation Field Representatives during scheduled accreditation site visits. A list of all specialties/subspecialties and their specific dedicated time requirements is available under "Selected Topics across Program Requirements" on the Institutional Application and Requirements page of the ACGME website.

6. Does the number of fellows in a Non-Standard Training program count towards the program director and program coordinator dedicated time?
   Answer: No. The full-time equivalent (FTE) percent entered should reflect *only* the time the program director and program coordinator dedicate to administration of the specific ACGME-accredited program you are completing the ADS Annual Update for.

7. Is the core faculty dedicated time question specific to individual faculty members or an aggregate dedicated time for core faculty members?
   Answer: The question in the ADS Annual Update regarding core faculty members' dedicated time asks for the aggregate FTE support for the minimum number of required faculty members in the program.

8. Can the core faculty dedicated time be shared among faculty members? For example, if a program requires three core faculty members and a minimum aggregate FTE .3, can this minimum be split among five core faculty members?
   Answer: Review the specialty-specific Program Requirements and contact the Executive Director of the specialty Review Committee for specialty-specific guidance, as this can vary among specialties. The Review Committee for Internal Medicine, for example, allows programs, in partnership with their Sponsoring Institution, to allocate and distribute the aggregate FTE as they see fit.

Resident/Fellow Roster Questions

1. Should residents/fellows starting June 24 be entered into ADS prior to the ADS rollover?
   Answer: No. Programs should only add new residents/fellows after the annual ADS rollover has occurred on June 29, 2024.

2. Should a program "graduate" residents/fellows prior to or after the rollover?
   Answer: Programs should update their Resident/Fellow Roster after the rollover. As part of the rollover process, residents/fellows will automatically be moved to the next PGY or to a graduated status, and programs can confirm or edit that information after the rollover (June 29 for 2024) or during the ADS Annual Update.

Faculty Roster, Board Certification, and Scholarly Activity Questions

1. Should new faculty members be added to ADS as they join the program or only during the ADS Annual Update?
   Answer: Programs should add faculty members to ADS as they join the program, during the ADS Annual Update window, or in preparation for an accreditation or recognition site visit.

2. If a graduating resident/fellow will be joining as a member of the program faculty, when should such an individual be added to the Faculty Roster in ADS, and will the record auto-populate with that individual's name/National Program Identifier (NPI) number?
   Answer: Physicians should not be added to the Faculty Roster while they are still indicated as a resident or fellow in ADS. After the rollover, programs must review and confirm their Resident/Fellow Roster, and specifically the residents'/fellows' PGY or graduated status. Once this step is complete, programs can add an individual who has graduated as a faculty member on the Faculty Roster. When entering faculty members, programs will be prompted to search for individuals using their first and last name and email address or NPI number. Programs will be able to select an existing profile to use when entering such information.

3. When should a new program update the Faculty Roster if changes occurred since the application submission?
   Answer: Programs may update their Faculty Roster at any time, although they are not required to make updates until they achieve Initial Accreditation. These changes will not be reflected in the application if it has been already submitted.

4. If an associate program director is leaving in September, when should the program update ADS?
   Answer: The associate program director should not be removed from ADS prior to the actual departure date if that individual still needs ADS access for program-level data or the Case Log System.

5. Will programs need to confirm the American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) certification data for physician faculty members?
   Answer: Programs are expected to review faculty members' profile data, including the board certification data provided by the ABMS or AOA. If certification information is correct, no further action is needed. If certification information is not populating or is incorrect, data should be provided in the manual entry section of a faculty member's profile.

6. What should a program do if a physician faculty member's board certification information is not populating in the faculty profile?
   Answer: The program should verify the accuracy of information in each faculty member's profile, including NPI number, medical school graduation date, residency information, etc. Faculty members' names in ADS should be the same as the name associated with their NPI number. If a faculty member's profile information has been verified, then the faculty member should contact the certifying board to ensure the physician profile information is accurate and certification information is shareable. If a match is still not identified, the program can use the manual entry option available to provide the certification information for that faculty member.

7. What should programs do about faculty members exempt from board certification, faculty members who are eligible for board certification but not yet certified, faculty members in subspecialties where there is no board certification, etc.?
   Answer: The ACGME will continue to expect programs to manually provide information on other types of certifications outside ABMS and AOA, faculty members who are board-eligible but not yet certified, faculty members who are not certified by any board, etc. If that information was previously entered in ADS, it will continue to display on the faculty member's profile and in the program's Faculty Roster. If a faculty member's profile included a manual entry stating that individual's board eligibility, and that individual has now achieved board certification and the information is automatically populating in the ABMS or AOA section of their profile, the program should remove the manual entry.

8. Will certification information populate when/if a program adds new faculty members?
   Answer: Yes, for new faculty members, the ABMS and AOA data will be populated in their faculty profiles within 24 hours if a match is identified. One of the key data points used to match a faculty member against the ABMS and AOA datasets is the NPI number, so programs must ensure the NPI number for new faculty members is provided and is correct.

9. How should programs enter non-physician faculty members' certification?
   Answer: A manual entry option is available and should be used to enter any certifications for non-physician faculty members.

10. If a faculty member's NPI information was flagged in ADS as "not matching" (e.g., name misspelled), should physicians contact the National Plan and Provider Enumeration System (NPPES) NPI Registry to update the information, or are there other steps programs can take to ensure information is accurate and updated?
    Answer: Programs and faculty members are encouraged to update the NPPES NPI database or the faculty member's profile in ADS to ensure correct and matching information across these systems. To submit a faculty name change request to ADS, email the program code (10-digit program ID number), the person's NPI number, and the correction to ADS@acgme.org.

11. Can programs copy faculty scholarly activity entered for the same faculty member by another program?
    Answer: For faculty members who serve across multiple programs and institutions, scholarly activity can be copied from one program to another on the Faculty Scholarly Activity tab in ADS. The copy option will only be enabled if a scholarly activity record is available to copy from another program. If a program has faculty members with multiple faculty profiles in ADS and believes the copy function is not available because a match of the correct profile has not been identified, email ADS@acgme.org to inquire about consolidating faculty members' profiles.

Site Visit Questions

1. Can a program have a site visit between the ADS annual rollover period and the beginning of the ADS Annual Update window?
   Answer: The ACGME will not schedule any accreditation or recognition site visits between June 29 (ADS rollover) and July 14, 2024. Site visits will resume July 15, 2024.

2. If a program's accreditation or recognition site visit is scheduled for mid-August, but its ADS Annual Update is due on September 20, can the program be part of the first update period so that its ADS Annual Update is completed before the site visit?

Answer: The documents and responses required for the ADS Annual Update and preparation for an accreditation or recognition site visit are similar but not identical. Programs are required to update ADS and complete their document uploads 14 days prior to an accreditation or recognition site visit. Instructions on what needs to be updated in ADS prior to the accreditation or recognition site visit are provided in the Site Visit Announcement Letter, in the “Updating ADS” section. For additional information related to site visits, see additional FAQs.

Resources

1. Where can programs find resources for completing the ADS Annual Update for 2024-2025?
   Answer: An overview of the ADS Annual Update for 2024-2025, FAQs, a summary of changes, and other resources are available in the ADS Help Center.

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Checklist for Updating the Accreditation Data System (ADS) Prior to an Accreditation or Recognition Site Visit

Please read these instructions carefully in preparation for your accreditation or recognition site visit. The due date for updates to ADS is indicated in the Field Activities Site Visit Announcement letter. Other documents may be requested by the Accreditation Field Representative(s). Detailed descriptions of each required upload can be found in ADS. Reviewers see only the templates and not the resident/fellow files or sample evaluations. Email any technical issues or questions about ADS to ADS@acgme.org and dfascheduling@acgme.org.

⚠️ **Warning!** Update ADS by the due date indicated in the Site Visit Announcement letter. Failure to update the ADS information may result in a postponement of the site visit and assessment of a $3,200 fine.

Instructions

- Log into the Accreditation Data System (ADS)
- Click the “Uploads” tab
- Read the upload instructions in ADS
- Upload by the due date listed in the Site Visit Announcement letter

For all site visits, ensure all data listed in ADS is up to date and accurate, especially:

☐ Rosters (faculty member and resident/fellow, if applicable)
☐ Responses to citations (if appliable)
☐ The Major Changes and Other Updates section
☐ Site Visit Attestation Statement

Other uploads required for a site visit differ by organization type and accreditation/recognition status. Detailed descriptions of each required upload can be found in ADS. Checklists of the applicable uploads are listed on the following pages, grouped by:

- Program – Accreditation – Application
- Program – Accreditation – Initial Accreditation Statuses
- Program – Accreditation – Continued Accreditation Statuses or Probationary Accreditation
- Program – Recognition – Initial Recognition Statuses
- Program – Recognition – Continued Recognition Statuses
- Sponsoring Institution – Accreditation – All Statuses

Program – Application Statuses
Site Visit Uploads ☐ Schedule of Didactics, Conferences, and Other Educational Activities

Program – Initial Accreditation Statuses
Updated Application ☐ Specialty-Specific Application Questions ☐ Block Diagram (use specialty-specific templates if applicable) ☐ Program Letters of Agreement ☐ Policy for Clinical and Educational Work Hours ☐ Policy for Supervision of Residents/Fellows ☐ Goals and Objectives ☐ Resident/Fellow Evaluation of Program ☐ Faculty Evaluation of Program ☐ Evaluation of Faculty Member by Resident/Fellow ☐ Evaluation of Resident/Fellow by Faculty Member ☐ Multi-source Evaluation of Resident/Fellow ☐ Semiannual, Summative, and Final Resident/Fellow Evaluations ☐ Policy for Resident/Fellow and Faculty Member Well-being ☐ For Rural Track Programs, Specialty-Specific Rural Track Program Questionnaire **Site Visit Uploads** ☐ Resident/Fellows Files ☐ Schedule of Didactics, Conferences, and Other Educational Activities ☐ Sample of a Completed Annual Evaluation of a Faculty Member by Residents/Fellows ☐ Program-Specific Policies and Guidelines ☐ Sample of Work Hour Report Data ☐ Documents Demonstrating Resident/Fellow Participation in Quality Improvement Activities

Program – Continued Accreditation Statuses, Probationary Accreditation
Site Visit Uploads ☐ Block Diagram (use specialty-specific templates if applicable) ☐ Program Letters of Agreement ☐ Resident/Fellow Files ☐ Example of Competency-Based Goals and Objectives ☐ Schedule of Didactics, Conferences, and Other Educational Activities ☐ Sample of a Completed Annual Evaluation of a Faculty Member by Residents/Fellows ☐ Program-Specific Policies and Guidelines ☐ Sample of Work Hour Report Data ☐ Documents Demonstrating Resident/Fellow Participation in Quality Improvement Activities

Program – Initial Recognition Statuses
Updated Application ☐ Form(s) Used for Formative Evaluation of Designated Osteopathic Residents ☐ Form Used for Final Evaluation of Designated Osteopathic Residents ☐ Designated Osteopathic Resident Appointment Policy ☐ Form(s) Used for Evaluation of Program by Osteopathic Faculty Members ☐ Form(s) Used for Evaluation of Osteopathic Faculty ☐ Form(s) Used for Evaluation of Program by Designated Osteopathic Residents ☐ Block Diagram (use specialty-specific templates if applicable) ☐ Osteopathic Recognition Specific Questions ☐ Shared Faculty Plan (if applicable) **Site Visit Uploads – Osteopathic Recognition** ☐ Resident/Fellow Files ☐ Osteopathic Skills Evaluations ☐ Educational Program Documentation ☐ Completed Annual Evaluation of Osteopathic Faculty Members ☐ Completed Program Evaluations Completed by Designated Osteopathic Residents/Fellows ☐ Completed Program Evaluations Completed by Osteopathic Faculty Members

Program – Continued Recognition Statuses, Probationary Recognition
Site Visit Uploads ☐ Resident/Fellow Files ☐ Faculty Development List ☐ Educational Program Documentation ☐ Completed Annual Evaluation of Osteopathic Faculty Members ☐ Completed Program Evaluations Completed by Designated Osteopathic Residents/Fellows ☐ Completed Program Evaluations Completed by Osteopathic Faculty Members ☐ Block Diagram (use specialty-specific templates if applicable)

Sponsoring Institution – All Statuses
Site Visit Uploads ☐ Documentation of Patient Care for Participating Sites that Are Hospitals ☐ Written Policies ☐ Sample(s) of the Residents'/Fellows' Agreement(s) of Appointment/Contract ☐ Professional Liability Coverages for Residents/Fellows **Institutional Review Questionnaire** ☐ Organizational Chart 1, Position of Designated Institutional Official (DIO) ☐ Organizational Chart 2, Position of Graduate Medical Education Committee (GMEC) ☐ Statement of Commitment ☐ GMEC Membership ☐ Annotated GMEC Minutes ☐ Annual Institutional Review Summaries ☐ GMEC Special Review Protocol ☐ Special Review Reports (if available) **Only for 10-Year Accreditation Site Visit** ☐ Summary of Achievements

ACGME

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

POLICIES AND PROCEDURES

Effective Date: February 2, 2025

ACGME Approved: 2/2/2025
ACGME Approved: 9/28/2024
ACGME Approved: 6/8/2024
ACGME Approved: 10/18/2023
ACGME Approved: 6/10/2023
ACGME Approved: 11/19/2022 (NST Policy)
ACGME Approved: 2/5/2022
ACGME Approved: 11/1/2021 (Major Policy Review and Update)
ACGME Approved: 6/12/2021 (OPC Name Change)
ACGME Approved: 9/26/2020 (New Mission and Vision Statement)
ACGME Approved: 6/13/2020
ACGME Approved: 4/16/2020
ACGME Approved: 3/21/2020
ACGME Approved: 9/28/2019
ACGME Approved: 9/29/2018
ACGME Approved: 6/9/2018
ACGME Approved: 2/3/2018
ACGME Approved: 9/23/17
ACGME Approved: 6/10/2017
ACGME Approved: 2/4/2017
ACGME Approved: 9/24/2016
ACGME Approved: 2/6/2016
ACGME Approved: 6/13/2015
ACGME Approved: 2/7/2015
ACGME Approved: 1/1/2015
ACGME Approved: 9/27/2014
ACGME Approved: 6/14/2014
ACGME Approved: 1/31/2014
ACGME Approved: 6/8/2013

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ACGME Approved: 9/29/2012
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ACGME Approved: 9/14/2009
ACGME Approved: 6/15/2009
ACGME Approved: 2/9/2009
ACGME Approved: 9/15/2008
ACGME Approved: 6/9/2008
ACGME Approved: 2/12/2008
ACGME Approved: 6/12/2007
ACGME Approved: 9/12/2006
ACGME Approved: 6/27/2006
ACGME Approved: 2/14/2006
ACGME Approved: 6/28/2005
ACGME Approved: 9/2002
ACGME Approved: 9/2001

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ACGME Structure and Function **9**

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ACGME Structure and Function

1.00 Mission and Scope, Vision, and Values of the Accreditation Council for Graduate Medical Education (ACGME)

1.10 Mission and Scope

The Accreditation Council for Graduate Medical Education (ACGME) is a not-for-profit, non-governmental organization responsible for the accreditation of graduate medical education (GME) programs and the institutions that sponsor them in the United States, its territories, and possessions. Its mission is to improve health care and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education. The ACGME has seven Member Organizations:

- American Board of Medical Specialties (ABMS)
- American Hospital Association (AHA)
- American Medical Association (AMA)
- Association of American Medical Colleges (AAMC)
- Council of Medical Specialty Societies (CMSS)
- American Osteopathic Association (AOA)
- American Association of Colleges of Osteopathic Medicine (AACOM)

Each Member Organization nominates four individuals to the ACGME Board of Directors (ACGME Board). Each Member Organization nominates two individuals per directorship, and the ACGME Board elects the directors. In addition, the ACGME Board includes three public directors, up to four at-large directors, three resident or fellow directors), and the Chair(s) of the ACGME Council of Review Committee Chairs and Council of Public Members. Two representatives of the federal government may, without vote, attend meetings of the ACGME Board.

Under the delegated authority of the ACGME Board, accreditation of Sponsoring Institutions and GME programs is carried out by the Review Committees and recognition of Sponsoring Institutions and programs is carried out by the Recognition Committees, both subject to appeal of adverse actions to the ACGME Board.

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1.00 Mission and Scope, Vision, and Values of the Accreditation Council for Graduate Medical Education (ACGME)

1.20 ACGME Vision

We envision a health care system where the Quadruple Aim[1] has been realized. We aspire to advance a transformed system of graduate medical education with global reach that is:

- Competency-based with customized professional development and identity formation for all physicians;
- Led by inspirational faculty role models, overseeing supervised, humanistic, clinical educational experiences;
- Immersed in evidence-based, data-driven, clinical learning and care environments defined by excellence in clinical care, safety, cost effectiveness, professionalism, and diversity, equity, and inclusion;
- Located in health care delivery systems equitably meeting local and regional community needs; and,
- Graduating residents and fellows who strive for continuous mastery and altruistic professionalism throughout their careers, placing the needs of patients and their communities first.

1.30 ACGME Values

We accomplish our Mission guided by our commitment to the Public Trust and the ACGME values of:

- Honesty and Integrity
- Accountability and Transparency
- Equity and Fairness
- Diversity, Equity, and Inclusion
- Excellence and Innovation
- Stewardship and Service
- Leadership and Collaboration
- Engagement of Stakeholders

1.40 ACGME Core Staff Values

- Integrity
- Reliability
- Community
- Professional Development
- Well-Being

[1] The Quadruple Aim simultaneously improved patient experience of care, population health, and health care practitioner work life, while lowering per capita cost.

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2.00 Purpose of Accreditation by the ACGME

Accreditation of Sponsoring Institutions and residency and fellowship programs by the ACGME is a voluntary, non-governmental peer-review process of evaluation. Accreditation benefits the public, protects the interests of residents and fellows, and improves the quality of teaching, learning, research, and professional practice.

The ACGME's accreditation processes are designed to evaluate, improve, and publicly acknowledge Sponsoring Institutions and programs in graduate medical education that are in substantial compliance with standards of educational quality established by the ACGME.

The ACGME has a twofold purpose:

a. to establish and maintain accreditation standards that promote the educational quality of residency and fellowship programs; and,

b. to promote residency/fellowship education that is sensitive to the quality and safety of patient care in an environment that fosters the well-being, learning, and professionalism of residents and fellows.

It is not the intent or purpose of the ACGME to establish numbers of physicians in any specialty.[2]

[2] At its meeting on February 13-14, 1984, the ACGME voted to reaffirm a statement of policy originally adopted by the Liaison Committee on Graduate Medical Education, the predecessor organization of the ACGME, at its November 17-18,1980 meeting.

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3.00 Diversity, Equity, and Inclusion for Composition of the ACGME Board and Committees

The ACGME is committed to diversity, equity, inclusion, justice, and advocacy in all its activities.

In soliciting and selecting from among professionally qualified nominees or applicants for ACGME committees, task forces, groups, appeals panels, and the Board of Directors, consideration shall be given to diversity, including without limitation, geography, specialty, gender identity, race, ethnicity, and sexual and gender minorities.

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4.00 Employee and Volunteer Whistleblower Policy

4.10 Raising Issues with the ACGME

The ACGME has an open-door policy and encourages employees and volunteers to share their questions, concerns, suggestions, or complaints with someone within the ACGME who can address them properly. In most cases, an employee's supervisor is in the best position to address such matters, particularly those related to human resources.

In addition, employees and volunteers may file a report anonymously via the ACGME's Compliance Hotline managed by Red Flag Reporting ("Compliance Case Management System") at 1.877.647.3335 (client code ACGME) or www.RedFlagReporting.com. Anonymous reporting will not impact the ACGME's commitment to conducting an investigation, and reporters can receive updates on the status of a report via the Compliance Case Management System.

4.20 Reporting Issues to the ACGME Audit and Risk Committee

If an employee or volunteer has serious concern that an ACGME employee or volunteer is acting in violation of (i) any state of federal law or related regulation, or (ii) the ACGME's corporate accounting practices, internal financial controls, or audit (collectively referred to as "Protected Disclosures"), the employee or volunteer is urged to directly notify the ACGME's Audit and Risk Committee Chair through Red Flag Reporting.

The Audit and Risk Committee Chair will promptly notify the sender of receipt of the concern regarding a Protected Disclosure unless the concern was submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

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5.00 Executive Committee of the ACGME

Subject to Article V, Section 13 of the ACGME Bylaws, the affairs of the ACGME shall be managed by the Executive Committee of the ACGME Board in the interim between regular or special meetings.

The Executive Committee consists of eight ACGME Directors. The ACGME Board Chair, Vice Chair or the Chair-Elect, and Treasurer shall serve in the same roles on the Executive Committee. The Chair of the ACGME Council of Review Committee Chairs shall serve on the Executive Committee. The remaining Directors on the Executive Committee shall be elected for two-year terms by the ACGME Board at its annual meeting from among the Directors on the Board.

The Executive Committee shall report to the ACGME Board as appropriate.

5.10 Policies and Procedures Advisory Committee to the Executive Committee

The Policies and Procedures Advisory shall advise the Executive Committee on new and proposed policies and procedures outlined in the ACGME Manual of Policies and Procedures.

5.11 Purpose

The Policies and Procedures Advisory Committee shall review the adequacy of the ACGME Manual of Policies and Procedures and propose revisions to the Executive Committee for consideration.

5.12 Composition

On recommendation of the ACGME Board Chair, the Governance Committee shall propose and the ACGME Board shall appoint from its members, a chair and vice-chair and Board members to serve on the Policies and Procedures Advisory Committee to the Executive Committee.

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6.00 Committees of the ACGME

6.10 Description

a. Standing Committees

- Finance Committee
- Audit and Risk Committee
- Compensation Committee
- Committee on Requirements
- Monitoring Committee
- Governance Committee
- Awards Committee
- Journal Oversight Committee
- Education Committee
- Policy Committee

b. Meetings

The standing committees shall meet at the time of the regular meetings of the ACGME Board, and/or at such other times as necessary.

c. Compensation

Members of the standing committees shall receive no financial compensation for their services but shall be reimbursed for travel and other necessary expenses incurred in fulfilling their duties as committee members.

d. Membership

Director members of standing committees shall be appointed as provided in Article VIII, Section 1 of the ACGME Bylaws. The majority of the members of each standing committee shall be ACGME Directors.

The ACGME Board may appoint one or more non-Director members to provide necessary expertise to a standing committee.

Non-Director members of standing committees, other than those nominated by the Council of Review Committee Chairs and the Council of Review Committee Residents, shall be appointed and reappointed for three consecutive one-year terms and may thereafter be invited to serve for one or more additional one-year terms.

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6.20 Finance Committee

6.21 Purpose

The Finance Committee shall:

a. prepare an annual budget for approval by the ACGME Board;

b. Meet prior to each regular meeting of the ACGME Board to review the financial status of the ACGME;

c. provide regular reports to the ACGME Board on the finances of the ACGME;

d. formulate the overall investment policies of the ACGME for its investment assets, subject to approval by the ACGME Board;

e. establish investment guidelines in furtherance of the investment policies;

f. monitor the management of the ACGME portfolio for compliance with the investment policies and guidelines and for meeting performance objectives over time; and,

g. perform such other duties relating to finances as may be assigned by the ACGME Board.

6.22 Composition

Subject to committee membership requirements in Article VIII, Section 1 of the ACGME Bylaws, on recommendation of the ACGME Board Chair, the Governance Committee shall propose and the ACGME Board shall appoint members to serve on the Finance Committee. The Committee is chaired by the ACGME Board Treasurer.

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6.00 Committees of the ACGME

6.20 Finance Committee

6.23 Operational Guidelines

The Committee shall review ACGME revenue and expenditures during the fiscal year. The ACGME fiscal year runs from January 1 to December 31. An annual budget for the next fiscal year shall be prepared for review and approval by the ACGME Board during each annual meeting. In so doing, the Committee shall:

a. recommend for ACGME Board approval all ACGME fees, per diems, and honorariums as part of the budgeting process;

b. review ACGME investments and recommend for ACGME Board approval the ACGME investment strategy;

c. recommend for ACGME Board approval the ACGME financial reserve strategy; and,

d. review and submit recommendations to the Executive Committee and/or the ACGME Board regarding all major capital expenditures and the financial impact of policies, practices, and/or procedures requested by ACGME committees or the ACGME Board.

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6.30 Audit and Risk Committee

6.31 Purpose

The Audit and Risk Committee shall:

a. recommend to the ACGME Board the selection, retention, and termination of the financial auditors of the ACGME;

b. provide oversight of the ACGME's internal system of financial control procedures and compliance activities;

c. provide oversight of the ACGME's internal system of risk management; and,

d. investigate any complaints of ACGME violation of state or federal law or of ACGME accounting practices, internal financial controls, or audit.

6.32 Composition

The Audit and Risk Committee shall consist of the public Directors of the ACGME Board and two or more additional committee members appointed as provided in Article VIII, Section 1 of the ACGME Bylaws. A majority of the Directors on the Audit and Risk Committee shall not simultaneously serve as members of the Finance Committee. At least one member of the Audit and Risk Committee must have expertise or experience in financial matters, and that member need not be a Director. Neither the President and Chief Executive Officer nor the Chief Finance and Administrative Officer of the ACGME may be a member of the Audit and Risk Committee but may advise and consult with the Audit and Risk Committee.

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6.40 Compensation Committee

6.41 Purpose

The Compensation Committee determines the annual compensation of the ACGME President and Chief Executive Officer and the Chief Finance and Administrative Officer. The Compensation Committee shall follow procedures provided by federal law to determine the compensation in a manner that results in a presumption of reasonableness under federal law.

6.42 Composition

The Compensation Committee consists of members appointed as provided in Article VIII, Section 1 of the ACGME Bylaws who are free from conflicts of interest with regard to determination of compensation.

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6.50 Committee on Requirements

6.51 Purpose

The Committee on Requirements shall review and make recommendations to the ACGME Board on all matters pertaining to the requirements submitted by Review and Recognition Committees (hereafter referred to as ACGME Committees). This includes, but is not limited to, recommendations on proposed institutional, recognition, Common Program, and specialty-specific program requirements (unless otherwise specifically identified, these are collectively referred to as "requirements").

6.52 Composition

Subject to membership requirements in Article VIII, Section 1 of the ACGME Bylaws, on recommendation of the ACGME Board Chair, the Governance Committee shall propose and the ACGME Board shall appoint members to serve on the Committee on Requirements. The Council of Review Committee Chairs (CRCC) shall nominate, through the Governance Committee for appointment by the ACGME Board, one member to serve a maximum two-year term. The term of the CRCC member must not extend beyond the individual's CRCC term.

6.53 Operational Guidelines

The Committee on Requirements shall review and evaluate new and revised requirements on the basis of:

a. content, including consistency with ACGME policies and procedures, clarity of language, and general reasonableness of standards; and,

b. impact, such as effects on patient care, resident/fellow education, residency/fellowship programs in other disciplines, and on the financial position of a Sponsoring Institution and its ACGME-accredited and/or recognized programs.

With respect to content that is specialty-specific (e.g., types of procedures and experiences necessary for resident/fellow education), the Committee on Requirements and the ACGME may rely on the expertise of the appropriate ACGME Committee and comments received from the community of interest, as applicable.

The Committee on Requirements shall review each set of requirements every 10 years in accordance with Policy 11.20.b.2. In addition, the Committee on Requirements will review interim revisions proposed by the applicable ACGME Committee.

The Committee on Requirements meetings shall include an open forum in which any member or representative of an ACGME Committee or of a Sponsoring Institution, program, organization, or the public with an interest in the requirements being reviewed and discussed may speak to the relevant issues. Representatives of the proposing ACGME Committee should have opportunity to respond to comments from interested parties.

The recommendation of the Committee on Requirements shall be presented to the ACGME Board for final action.

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6.00 Committees of the ACGME

6.50 Committee on Requirements

6.54 Resolution of Inter-Specialty and Multi-Specialty Conflicts

There may be circumstances in which proposed requirements appear to have an adverse impact on either residency/fellowship education in other disciplines or on patient safety. The Committee on Requirements shall exclusively evaluate such issues and shall encourage the interested parties to articulate the issues at hand. The Committee on Requirements shall review all available information, including comments by interested parties and the public, and shall have the opportunity to ask questions and seek additional information. The Committee on Requirements shall make a recommendation to the ACGME Board on the requirements after considering all information that it judges relevant and appropriate.

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6.60 Monitoring Committee

6.61 Purpose

The Monitoring Committee oversees the work of the Review Committees. In this role, it has the following responsibilities:

a. make recommendations to the ACGME Board regarding Review Committee activities and delegation of accreditation authority based on evaluation and the Review Committee's performance, including consistency of decision-making, within and among the Review Committees;

b. accrue and disseminate knowledge about improving accreditation practices by:

   1. oversight of administrative development and distribution of summary information regarding the performance of the Review Committees;

   2. identification and dissemination of salutary practices of Review Committees; and,

   3. recommendation, where appropriate, of standardized approaches to requirements construction and enforcement;

c. monitor and assess the consistent application and enforcement of the requirements;

d. recommend research on requirements and accreditation methods, including review of proposed methods and evaluation of results;

e. review accreditation data and information addressing special issues as directed by the ACGME Board; and,

f. make recommendations to the ACGME administration regarding the processes, policies and procedures for Review Committee administration, requirements construction, and accreditation decision making.

6.62 Composition

Subject to committee membership requirements in Article VIII, Section 1 of the ACGME Bylaws, on recommendation of the ACGME Board Chair, the Governance Committee shall propose and the ACGME Board shall appoint members to serve on the Monitoring Committee. The Council of Review Committee Chairs (CRCC) shall nominate, through the Governance Committee for appointment by the ACGME Board, one member to serve a maximum two-year term. The term of the CRCC member on the Monitoring Committee must not extend beyond the individual's CRCC term.

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6.00 Committees of the ACGME

6.60 Monitoring Committee

6.63 Operational Guidelines

a. Review and Recognition Committees

The Monitoring Committee shall review the performance of each Review or Recognition Committee.

The Monitoring Committee may invite representatives of each Review or Recognition Committee, including the Review or Recognition Committee Chair, and others as appropriate, to discuss and clarify the Review or Recognition Committee's activities.

Based on the annual and/or 10-year evaluation of the Review or Recognition Committee, the Monitoring Committee shall recommend one of the following options:

1. continue to delegate accreditation or recognition authority; or,
2. continue to delegate accreditation or recognition authority with added supervision and oversight; or,
3. withdraw delegation of accreditation or recognition authority, with an accompanying plan for replacement of the accreditation or recognition function.

b. Specialty, Subspecialty, and Sub-Subspecialty Accreditation

The Monitoring Committee shall periodically review and make recommendations to the ACGME Board regarding the continued accreditation designation of a specialty, subspecialty, or sub-subspecialty.

This review shall include consideration of the number of programs that have been accredited, the number of filled resident and/or fellow positions, staff and other support requirements for accreditation, and other relevant information.

If the Monitoring Committee finds any "Criteria for Designation" (Policies 12.10, 12.20, 12.30 and 13.10) are not met, it may recommend one of the following:

1. accreditation of programs should continue for a specified period of time to determine if the criteria can be met (at the conclusion of which time another review shall be conducted); or,
2. accreditation of programs should be discontinued in which case the Monitoring Committee shall recommend an effective date of discontinued accreditation.

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6.00 Committees of the ACGME

6.60 Monitoring Committee

6.63 Operational Guidelines

c. At the end of the five-year provisional approval period for new specialties, subspecialities, and sub-subspecialties, the Monitoring Committee shall consider whether the ACGME should continue to accredit such programs. This review shall include consideration of the number of programs that have been accredited, the number of filled resident and/or fellow positions, availability of Review Committee expertise, staff and other support requirements for accreditation, and other relevant information. The Monitoring Committee shall also consider "Criteria for Designation" (Policies 12.10, 12.20, 12.30 and 13.10).

   If the Monitoring Committee finds that this information does not support the continued accreditation of programs in the specialty, subspecialty, or sub-subspecialty, it may recommend discontinuing to delegate accreditation authority and closure of these programs or transfer of the programs in the case of multidisciplinary subspecialties to a different parent specialty/Review Committee. The Monitoring Committee shall recommend a preferred plan with an effective date of this action.

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6.70 Governance Committee

6.71 Purpose

The Governance Committee shall:

a. serve as the nominating committee for elected Directors who are not nominated by ACGME Member Organizations, for non-officer members of the Executive Committee, and for elected officers;

b. recommend nominees to the ACGME Board of Directors from among the director nominees of ACGME Member Organizations;

c. maintain records of skills and experience needed on the ACGME Board, and of potential nominees by category of skills and experience, including serving as a source of qualified non-Director appointees to various ACGME Board committees where permitted by the ACGME Bylaws or by the resolution creating the standing or special committee;

    1) Among the factors addressed in this selection process of creating the standing or special committees, committees should solicit and consider candidates consistent with Policy 3.00.

d. on recommendation of the ACGME Chair, propose members to serve on standing committees;

e. plan, oversee, and evaluate new Director orientation for the ACGME Board;

f. plan, oversee, and evaluate all continuing education related to the ACGME Board's role in governance, encourage participation, and leverage the qualifications and experiences of each Director to benefit the entire ACGME Board;

g. conduct at least annual evaluations of the members of the ACGME Board as a whole and share appropriately the results thereof;

h. oversee the implementation of the ACGME's policy on confidentiality and deliberate on breaches of the policy to make recommendations to the ACGME Board for action or sanctions;

i. oversee the implementation of the ACGME's policy on conflicts and dualities of interest; review all disclosed conflicts and dualities for appropriate response, if any; and deliberate on breaches of the policy to make recommendations to the ACGME Board for action or sanctions;

j. review the ACGME Bylaws and/or organizational documents of the ACGME at least biannually as to their effectiveness and currency; and,

k. perform such other duties relating to governance as may be assigned by the ACGME Board.

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6.00 Committees of the ACGME

6.70 Governance Committee

6.72 Composition

The Governance Committee shall consist of one Director nominated by each ACGME Member Organization, at least one public Director, and the Chair of the Council of Review Committee Chairs.

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6.80 Awards Committee

6.81 Purpose

a. The Awards Committee shall review and make recommendations to the ACGME Board on all matters pertaining to the ACGME Awards Program.

b. The Awards Committee shall submit nominations to the ACGME Board for the:

- Parker J. Palmer Courage to Teach Award;
- Parker J. Palmer Courage to Lead Award;
- John C. Gienapp Award;
- David C. Leach Award;
- ACGME and Gold Foundation DeWitt C. Baldwin Jr. Award;
- GME Institutional Coordinator Excellence Award;
- Debra L. Dooley Program Coordinator Excellence Award;
- Barbara Ross-Lee, DO Diversity, Equity, and Inclusion Award; and,
- other awards as determined by the ACGME Board.

6.82 Composition

Subject to committee membership requirements in Article VIII, Section I of the ACGME Bylaws, on recommendation of the ACGME Board Chair, the Governance Committee shall propose and the ACGME Board shall appoint members to serve on the Awards Committee. The Vice Chair of Council of Review Committee Chairs (CRCC) will serve a two-year term on the Awards Committee which may extend beyond the term as Vice Chair of the CRCC. There must be a resident or fellow member on the Awards Committee.

A current member of the ACGME Coordinator Advisory Group will serve on the Awards Committee as a voting member.

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6.90 Journal Oversight Committee

6.91 Purpose

The Journal Oversight Committee shall:

a. guide the business affairs of the *Journal of Graduate Medical Education* (*JGME*) with the aim of promoting high-quality scholarship and dissemination;

b. ensure *JGME*'s financial viability and editorial independence; and,

c. make recommendations to the ACGME Board regarding structure, support, and production of *JGME*.

6.92 Composition

Subject to committee membership requirements in Article VIII, Section 1 of the ACGME Bylaws, on recommendation of the ACGME Board Chair, the Governance Committee shall propose and the ACGME Board shall appoint members to serve. the Journal Oversight Committee, who shall include at least one public Director. The Editor-in-Chief will serve in a non-voting, ex-officio capacity. There must be a resident or fellow member on the Journal Oversight Committee.

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6.93 Operational Guidelines

The Journal Oversight Committee shall:

a. monitor all activities associated with the publication of *JGME*, including receipt, at least annually, of a report on *JGME* from the senior administration of the ACGME and senior editorial staff of the journal;

b. approve the selection of the Editor-in-Chief and advise appointment of deputy editors and associate editors to ensure diversity of expertise;

c. approve the duties of the Editor-in-Chief, deputy editors, and associate editors;

d. periodically evaluate the Editor-in-Chief, review the Editor-in-Chief's evaluations of the deputy editors and associate editors, and make decisions on retention;

e. approve the remuneration of the Editor-in-Chief within a budget that has been approved by the ACGME Board;

f. review and recommend to the ACGME Board changes in pricing, publication volume, publication frequency, and distribution of *JGME*;

g. work with the ACGME's senior administration, the Editor-in-Chief, and the Managing Editor, to develop and implement a budget to support *JGME*, which will annually be subject to the approval of the ACGME Board;

h. offer guidance in matters of overall direction for *JGME*, as requested by the Editor-in-Chief or the ACGME Board; and,

i. report at least annually to the ACGME Board on *JGME* operations.

6.94 Meetings

The Journal Oversight Committee shall meet during at least two of the regular ACGME Board meetings and, as needed, by teleconference to discuss ongoing efforts for review and endorse any proposed policies. Subject to the approval and oversight of the ACGME Board as stated herein, the Journal Oversight Committee shall oversee the business activities of *JGME*.

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6.00 Committees of the ACGME

6.100 Education Committee

6.101 Purpose

The Education Committee shall:

a. monitor the quality and performance of ACGME-sponsored education activities;

b. serve as a resource for the development of new ACGME education activities and initiatives; and,

c. make recommendations to the ACGME Board with regard to ongoing educational activities and development of new education initiatives.

6.102 Composition

Subject to committee membership requirements in Article VIII, Section I of the ACGME Bylaws, on recommendation of the ACGME Board Chair, the Governance Committee shall propose and the ACGME Board shall appoint members to serve on the Education Committee.

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6.00 Committees of the ACGME

6.110 Policy Committee

6.111 Purpose

The Policy Committee shall develop and recommend positions to the ACGME Board relating to policy issues that affect accreditation and graduate medical education.

6.112 Composition

Subject to committee membership requirements in Article VIII, Section 1 of the ACGME Bylaws, on recommendation of the ACGME Board Chair, the Governance Committee shall propose and the ACGME Board shall appoint members to serve on the Policy Committee.

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7.00 Councils of the ACGME

7.10 Description

a. Purpose

The Council of Review Committee Chairs, the Council of Review Committee Residents, and the Council of Public Members advise the ACGME in matters pertaining to graduate medical education accreditation and recognition.

b. Meetings

The Councils typically meet at least twice a year and may meet at the time of the regular meetings of the ACGME Board and at such other times as necessary.

c. Reporting

The Councils shall report to the ACGME Board and to the Executive Committee as appropriate.

d. Compensation

Council members shall receive no financial compensation for their services but shall be reimbursed for travel and other necessary expenses incurred in fulfilling their duties as Council members.

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7.00 Councils of the ACGME

7.20 ACGME Council of Review Committee Chairs

7.21 Purpose

The ACGME Council of Review Committee Chairs (CRCC) recommends to the ACGME administration and the ACGME Board approaches to improve educational outcomes within and across clinical specialties, policies and procedures that guide accreditation and recognition, and other matters as charged by the ACGME administration or the ACGME Board.

7.22 Composition

The CRCC is composed of the current chairs of all Review and Recognition Committees, two resident or fellow ACGME Directors, and one public Director appointed by the ACGME Board. A representative from the Royal College of Physicians and Surgeons of Canada, a representative from the Organization of Program Director Associations, and a representative from the Veterans Administration are official observers without vote.

The CRCC shall elect its Chair from among its own members. The CRCC Chair shall serve a single term of two years and must be a Committee Chair at the time of election but need not be a Committee Chair or member for the duration of the two-year term. The CRCC Chair shall serve as a Director on the ACGME Board and as a voting member of the Executive Committee.

The CRCC shall also elect its Vice Chair from among its own members for a two-year term. The CRCC Vice Chair may participate in meetings of the ACGME Board, except that the Vice Chair shall not be entitled to vote.

The CRCC shall nominate, through the ACGME Board Chair and the Governance Committee for appointment by the ACGME Board, one of its members to serve a two-year term as a voting member on each of the following: Committee on Requirements, Monitoring Committee, Awards Committee, and Education Committee. One CRCC member will be appointed by the CRCC Chair to serve as a liaison to the Council of Review Committee Residents. The terms of the CRCC Chair and CRCC Vice-Chair, and the standing committee terms of the CRCC standing committee members shall begin and end upon adjournment of the annual meeting of the ACGME Board.

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7.30 ACGME Council of Review Committee Residents

7.31 Purpose

The ACGME Council of Review Committee Residents (CRCR) serves as an advisory body to the ACGME concerning resident/fellow matters, graduate medical education, accreditation, and recognition.

7.32 Composition

The CRCR is composed of the current resident and/or fellow members of the ACGME Board and the Review and Recognition Committees and one ACGME public Director appointed by the ACGME Board.

The CRCR shall elect its Chair from among its own members. The CRCR Chair shall serve a single term of two years. The CRCR Chair must be a member of a Committee at the time of election but need not be a Committee member for the duration of the two-year term. The CRCR Chair shall serve as a Director on the ACGME Board.

The CRCR shall also elect its Vice Chair from among its own members for a one-year term. The CRCR Vice Chair shall be eligible for election as CRCR Chair only upon expiration of the term as Vice Chair. In the absence of the CRCR Chair, the Vice Chair may participate in meetings of the ACGME Board, except that the Vice Chair shall not be entitled to vote.

The CRCR shall nominate, through the ACGME Board Chair and the Governance Committee for appointment by the ACGME Board, one of its members to serve as a voting member on the Awards Committee and the Journal Oversight Committee. The terms of the CRCR Chair and CRCR Vice-Chair, and the standing committee terms of the CRCR standing committee members, shall begin and end upon adjournment of the annual meeting of the ACGME Board.

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7.40 ACGME Council of Public Members

7.41 Purpose

The ACGME Council of Public Members serves as an advisory body to the ACGME, increasing engagement on behalf of the American public.

7.42 Composition

The ACGME Council of Public Members is composed of one public member from each Review and Recognition Committee that has a public member; the public Directors of the ACGME Board; and, at the discretion of the ACGME Board, one or more at-large public members chosen by the ACGME Board who shall also determine the length of the additional public member term(s).

The Council of Public Members shall elect its Chair from among its own members. The Council of Public Members Chair shall serve a single term of two years. The term of the Council of Public Member Chair shall begin and end upon adjournment of the annual meeting of the ACGME Board. The Council of Public Members Chair must be a member of a committee at the time of election but need not be a committee member for the duration of the two-year term. The Council of Public Members Chair shall serve as a Director on the ACGME Board.

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8.00 ACGME Conduct

8.10 Fiduciary Duty

Members of the ACGME Board and Review and Recognition Committees hold a fiduciary duty to the ACGME. They must be attentive to the needs and priorities of the ACGME and must act in what they reasonably believe to be the best interests of the ACGME.

If any member cannot discharge this fiduciary duty of acting in the best interest of the ACGME on any particular issue, the member should declare a conflict or duality of interest as described in Policy 8.20.

8.20 Conflict and Duality of Interest Policy (Directors and Committee Members)

The mission of the ACGME is to improve health care and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education. In furtherance of this mission, the ACGME engages in accreditation, recognition, and accreditation and recognition-related activities. The integrity of the ACGME, its accreditation and recognition decisions, and the activities it undertakes, depend on:

a. the avoidance of conflicts of interest, or even the appearance of such conflicts, by the individuals involved in those decisions and activities; and,

b. appropriately addressing dualities of interest by those same individuals.

At the same time, the ACGME acknowledges that the leaders of the ACGME also have significant professional, business, and personal interests and relationships. Therefore, the ACGME has determined that the most appropriate manner in which a Director/Committee member addresses actual, apparent, or potential conflicts of interest and/or dualities of interest begins with full disclosure of any relationship or interest that might be construed as resulting in such a conflict or duality. Disclosure under this policy should not be construed as creating a presumption of impropriety or as automatically precluding someone from participating in an ACGME activity or decision-making process. Rather, it reflects the ACGME's recognition of the many factors that can influence a person's judgment and a desire to make as much information as possible available to all participants in ACGME-related matters.

Insofar as actual, apparent, or potential conflicts and dualities of interest can be addressed before they are manifest in ACGME Board or Committee meetings or otherwise, they should be referred to the ACGME Board or applicable Committee Chair for resolution (with assistance and advice of the ACGME President and Chief Executive Officer) and failing satisfactory resolution to all involved, to the Governance Committee for resolution. Insofar as actual, apparent, or potential conflicts of interest and dualities of interest are not so resolved, and they become manifest in ACGME Board or Committee meetings, the ACGME Board or Committee shall address them consistent with this policy, or if permitted by time, refer them to the Governance Committee for resolution.

On or before January 31 of each year, the ACGME President and Chief Executive Officer and each Committee shall submit to the Governance Committee a report listing the date and a brief account (need not include names) of each disqualification occurring during the previous calendar year.

The Governance Committee of the ACGME Board has the responsibility to provide oversight for compliance with this policy.

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8.00 ACGME Conduct

8.20 Conflict and Duality of Interest Policy (Directors and Committee Members)

8.21 Definitions

a. Conflict of Interest

A conflict of interest occurs when a Director/Committee member has a financial interest (as defined in this policy), which is declared or determined under this policy to be a personal and proprietary financial interest to the Director/Committee member or a close member of the Director's/Committee member's family that relates to an ACGME decision or activity.

b. Duality of Interest

A duality of interest occurs when a Director/Committee member has an interest, which is declared as or determined under this policy to be a competing fiduciary obligation that does not involve a personal and proprietary financial interest. (Usually, this relates to a fiduciary obligation to another not-for-profit corporation with an interest in ACGME accreditation requirements and policies.) A duality of interest sufficient in gravity to destroy the trust necessary for fiduciary service in the interest of the ACGME and the public on an issue shall disqualify a Director/Committee member from fiduciary service on that issue.

c. Apparent Conflict or Duality

An apparent conflict or duality of interest is one which is perceived, but not actual. (Since third parties act or draw conclusions on what they perceive, an apparent, but unresolved, conflict or duality needs to be addressed.)

d. Potential Conflict or Duality

A potential conflict or duality of interest is one that has not yet occurred, but is predictable if a Director/Committee member is about to assume:

1. ownership or investor status;

2. a compensation arrangement; or

3. fiduciary responsibility.

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8.00 ACGME Conduct

8.20 Conflict and Duality of Interest Policy (Directors and Committee Members)

8.21 Definitions

e. Financial Interest

A financial interest is personal and proprietary if a Director/Committee member has, directly or indirectly, through business, investment, or family (spouse, parent, child or spouse of a child, brother, sister, or spouse of a brother or sister):

1. an ownership or investment interest in any entity (other than a publicly held entity) with which the ACGME has a contract or transactional arrangement, or in any entity (other than a publicly held entity) whose products or services are in competition or potential competition with those intrinsic to the ACGME contract or transactional arrangement; or,

2. a compensation arrangement with any entity or individual with which/whom the ACGME has a contract or transactional arrangement in which the compensation is in excess of one thousand dollars ($1,000.00) in any year, or with any entity whose products or services are in competition or potential competition with those intrinsic to the ACGME contract or transactional arrangement; or,

3. an actual or potential ownership or investment interest in any entity (other than a publicly held entity) with which the ACGME is considering or negotiating a contract or transactional arrangement, or in any entity (other than a publicly held entity) whose products or services are in competition or potential competition with those intrinsic to the potential ACGME contract or transactional arrangement; or,

4. a compensation arrangement with any entity or individual as to which/whom the ACGME is considering or negotiating a contract or transactional arrangement, or with any entity or individual whose products or services are in competition or potential competition with those intrinsic to the potential ACGME contract or transactional arrangement.

   Compensation includes direct and indirect remuneration, as well as gifts or favors (in general those amounting to less than $50 per calendar year are exempt from this Policy).

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8.00 ACGME Conduct

8.20 Conflict and Duality of Interest Policy (Directors and Committee Members)

8.22 Procedure – Conflict of Interest – Contract or Transaction

a. Disclosure of Conflicts

All Directors/Committee members who have, or who are advised that they may have, (a) an actual, apparent, or potential conflict of interest (personal or proprietary financial interest) or (b) bias for or against a Sponsoring Institution or program under review, must disclose the conflict and all relevant facts to the ACGME Board Chair (ACGME Board Vice Chair if the ACGME Board Chair is conflicted or unavailable) or Committee Chair (Committee Vice Chair if the Committee Chair is conflicted or unavailable; Committee-selected designee if the Committee Chair is conflicted or unavailable, and there is no Committee Vice Chair). A disclosure statement form shall be provided to each Director and Committee member annually for completion and return, but disclosure is most appropriate whenever conflicts arise or are suspected.

b. Self-Declared Conflict (Disqualifying)

1. A Director/Committee member may declare an actual, apparent, or potential conflict of interest relating to ACGME Board or Committee action on a contract or transaction and shall disclose all facts material to the conflict of interest. Such disclosure and declaration shall be reflected in the minutes of the meeting, which need not state all the facts disclosed by the Director/Committee member.

2. The conflicted Director/Committee member shall not participate in or be permitted to hear the ACGME Board's or Committee's discussion of the contract or transaction except to disclose material facts and to respond to questions. The Director/Committee member shall not attempt to exert personal influence with respect to the contract or transaction, either at or outside the meeting.

3. The Director/Committee member having an actual or apparent conflict of interest may not vote on the contract or transaction and shall not be present in the meeting room when the vote is taken. Such a person's ineligibility to vote on that matter shall be reflected in the minutes of the meeting.

4. Depending upon the facts involved, the ACGME Board Chair or Committee Chair may also conclude that certain confidential or proprietary information should not be shared with the person having the actual, apparent, or potential conflict.

c. Same State or Territory (Accreditation Actions)

A Director/Committee member (a) employed by an ACGME-accredited Sponsoring Institution or program headquartered in the same state or territory as a Sponsoring Institution or program being considered for accreditation/recognition action by a Review or Recognition Committee or the ACGME Board and/or (b) having a bias for or against a Sponsoring Institution or program being considered for accreditation/recognition action by a Review or Recognition Committee or the ACGME Board shall withdraw from all discussion on the accreditation/recognition action and leave the meeting room. The person shall not attempt to exert personal influence with respect to the accreditation/recognition action, either at or outside the meeting.

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8.00 ACGME Conduct

8.20 Conflict and Duality of Interest Policy (Directors and Committee Members)

8.22 Procedure – Conflict of Interest – Contract or Transaction

d. ACGME Determined Conflict (Disqualifying)

1. In the event it is not entirely clear that an actual, apparent, or potential conflict of interest exists, the Director/Committee member with an alleged or suspected conflict shall disclose the circumstances to the ACGME Board Chair (ACGME Board Vice Chair if the ACGME Board Chair is conflicted or unavailable) or the Committee Chair (Committee Vice Chair if the Committee Chair is conflicted or unavailable; Committee-selected designee if the Committee Chair is conflicted or unavailable and there is no Committee Vice Chair), who shall determine whether there exists an actual, apparent, or potential conflict of interest.

2. The Director/Committee member may request a vote of the ACGME Board or Committee if the Director/Committee member disagrees with the determination of the ACGME Board Chair or Committee Chair. The Director/Committee member may be present and may speak during ACGME Board or Committee discussion of the relevant facts regarding the actual, apparent, or potential conflict of interest, but shall leave the room for other discussion and voting. An actual, apparent, or potential conflict may be found to exist by a simple majority vote, with the Director/Committee member involved not voting, but being counted for quorum purposes and shown as abstaining.

3. Depending upon the facts involved, the ACGME Board Chair or Committee Chair may also conclude that certain confidential or proprietary information should not be shared with the person having the actual, apparent, or potential conflict.

8.23 Procedure – Addressing Number of Persons Voting

If, upon conclusion of the Conflict of Interest Procedure (Policy 8.22), the number of persons remaining to discuss and vote on a matter is less than half the total number of persons, those persons excluded under Policy 8.22.c. (Same State or Territory) who would not otherwise be excluded under the Conflict of Interest Procedure (Policy 8.22) may participate in discussion and vote on the appeal of the Sponsoring Institution or program.

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8.00 ACGME Conduct

8.20 Conflict and Duality of Interest Policy (Directors and Committee Members)

8.24 Duality of Interest

a. Disclosure of Dualities and Possible Dualities

Prior to ACGME Board or Committee action on an issue, each Director/Committee member who has, or is advised by one or more on the ACGME Board or ACGME Committee that the individual may have, an actual, apparent, or potential duality of interest as regards an action being taken or to be taken by the ACGME Board or Committee, must disclose the duality and all relevant facts to the ACGME Board Chair (ACGME Board Vice Chair if the ACGME Board Chair is conflicted or unavailable) or the Committee Chair (Committee Vice Chair if the Committee Chair is conflicted or unavailable; Committee-selected designee if the Committee Chair is conflicted or unavailable and there is no Committee Vice Chair).

1. The affected Director/Committee member shall inform the ACGME Board or Committee how the individual Director/Committee member has acted in the public's best interest to resolve the duality.

2. Annual Disclosure Form: A disclosure statement form shall be provided to each Director/Committee member annually for completion and return, but disclosure is most appropriate whenever dualities arise or are suspected.

b. Self-Declared Actual, Apparent, or Potential Duality

1. Self-Declared Actual, Apparent, or Potential Duality (Non-Disqualifying)

Prior to ACGME Board or Committee action on a matter or issue, a Director/Committee member may declare an actual, apparent, or potential duality of interest on an issue, and also declare that the Director/Committee member can discharge the fiduciary duty relating to that issue in a manner that the Director/Committee member reasonably believes is in the interests of the ACGME and the public. Unless the ACGME determines, as provided herein, that the Director/Committee member has an actual, apparent, or potential duality of interest on an issue and that the Director/Committee member cannot discharge the fiduciary duty relating to that issue in a manner that is in the interests of the ACGME and the public, the Director/Committee member may participate regarding that issue.

2. Self-Declared Actual, Apparent, or Potential Duality (Disqualifying)

A Director/Committee member declaring an actual, apparent, or potential duality of interest on an issue, and that the Director/Committee member cannot discharge the fiduciary duty relating to that issue in a manner that the Director/Committee member reasonably believes is in the interests of the ACGME and the public, shall not participate regarding that issue.

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8.00 ACGME Conduct

8.20 Conflict and Duality of Interest Policy (Directors and Committee Members)

8.24 Duality of Interest

c. ACGME Determined Actual, Apparent, or Potential Duality (Disqualifying)

1. In the event it is not clear that a disqualifying actual, apparent, or potential duality of interest exists, the Director/Committee member with an actual, alleged, suspected, or possible actual, apparent, or potential duality shall disclose the circumstances to the ACGME Board Chair (ACGME Board Vice Chair if the ACGME Board Chair is conflicted or unavailable) or the Committee Chair (Committee Vice Chair if the Committee Chair is conflicted or unavailable; Committee-selected designee if the Committee Chair is conflicted or unavailable, and there is no Committee Vice Chair), who shall determine whether there exists a disqualifying actual, apparent, or potential duality of interest, i.e., whether an actual, apparent, or potential duality of interest exists that is sufficient in gravity to destroy the trust necessary for fiduciary service to the ACGME and the public on an issue.

2. The Director/Committee member involved may request a vote if the Director/Committee member disagrees with a disqualification decision of the ACGME Board Chair or Committee Chair. The Director/Committee member involved may be present and may speak during ACGME Board or Committee discussion of the relevant facts but shall leave the room for executive session discussion and voting. A disqualifying actual, apparent, or potential duality may be found to exist by a two-thirds vote, the Director/Committee member involved not voting, but being counted for quorum purpose and shown as abstaining.

d. Addressing Duality (Disqualifying)

Upon a disqualifying actual, apparent, or potential duality of interest being either declared or determined regarding an action being taken or to be taken by the ACGME Board or the ACGME Committee, the duality shall be noted in the minutes. The Director/Committee member with the actual, apparent, or potential duality shall not participate in the debate or vote on the action, and, at the discretion of the ACGME Board Chair or Committee Chair, shall not have access to certain confidential information.

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8.00 ACGME Conduct

8.20 Conflict and Duality of Interest Policy (Directors and Committee Members)

8.25 Procedure—Specialties under Consideration

a. Prior to and during an ACGME Board or Committee meeting at which a specialty is being considered (including but not limited to specialties addressed by the Monitoring and Requirements Committees), Directors/Committee members of the same specialty as that under consideration shall not (a) review, (b) participate in ACGME Board or Committee discussion, (c) participate in ACGME Board or Committee vote, and/or (d) moderate ACGME Board or Committee consideration of that specialty.

b. Prior to and during an ACGME Board or Committee meeting at which a specialty is being considered (including but not limited to specialties addressed by the Monitoring Committee and Committee on Requirements), no Director/Committee member shall (a) review, (b) participate in ACGME Board or Committee discussion, (c) participate in ACGME Board or Committee vote, and/or (d) moderate ACGME Board or Committee consideration of any specialty as to which the Director/Committee member, because of the individual's background or otherwise, feels the Director/Committee member cannot fairly participate in consideration.

c. During an ACGME Board or Committee meeting, prior to consideration of a specialty, the ACGME Board or Committee will determine whether any Director/Committee member, because of a conflict of interest, should not participate in consideration of the specialty.

d. If, as a result of the above process, two or fewer Directors/Committee members remain eligible to participate in ACGME Board or Committee recommendation on a specialty, the ACGME Board Chair shall appoint a Director without such conflicts to participate as an ad hoc Committee member for recommendation on a specialty.

e. A Director/Committee member having a conflict of interest shall withdraw from all consideration of the specialty and shall leave the meeting room during consideration.

8.26 Procedure—Consultant/Field Representative

A person shall not serve as an institutional or program consultant or as institutional or program Field Representative to graduate medical education Sponsoring Institutions or programs inside or outside the United States while serving on the ACGME Board or a Review or Recognition Committee.

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8.00 ACGME Conduct

8.20 Conflict and Duality of Interest Policy (Directors and Committee Members)

8.27 Failure to Disclose Conflict and Duality of Interest

If the Governance Committee has reasonable cause to believe (based on information from the ACGME President and Chief Executive Officer or other sources that a Director/Committee member has knowingly and deliberately failed to disclose an actual, apparent, or potential conflict or duality of interest, it shall inform the Director/Committee member of the bases for such belief and afford the Director/Committee member an opportunity to explain the alleged failure to disclose.

If, after hearing the response of the Director/Committee member and making such further investigation as may be warranted in the circumstances, the Governance Committee determines that the Director/Committee member has in fact knowingly failed to disclose an actual, apparent, or potential conflict or duality of interest, it shall recommend appropriate action or sanctions to the ACGME Board. The recommendation shall reflect the Governance Committee's view of the violation's seriousness and the degree of harm or potential harm to the ACGME.

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8.30 Annual Disclosure—Directors and Committee Members

Annually each Director/Committee member shall be provided with and asked to review a copy of this policy and to acknowledge in writing that the Director/Committee member has done so and that the Director/Committee member agrees to follow this policy.

Annually each Director/Committee member shall complete a disclosure form identifying any relationships, positions, or circumstances in which the Director/Committee member is involved that the Director/Committee member believes could contribute to an actual or apparent conflict or duality of interest. Any such information regarding the business interests of a person or a family member thereof shall generally be made available only to the ACGME Board Chair, the President and Chief Executive Officer, and any committee appointed to address conflicts and dualities of interest, except to the extent additional disclosure is necessary in connection with the implementation of this policy.

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8.40 Confidentiality

The ACGME acknowledges that adherence to confidentiality of the information acquired during the accreditation process is vital to its operation. Intrinsic to accreditation is the promotion of candor within its process, which may include constructive criticism that leads to improvement in the educational quality of an institution or program. Maintaining confidentiality within the accreditation process promotes this candor. Confidentiality means that the ACGME and its committees will not disclose the documents listed in this policy nor the information contained therein, except as required for ACGME accreditation purposes, as may be required legally, or as provided in Policy 8.41. To meet the requirement of confidentiality, the ACGME holds as confidential the following documents and the information contained therein:

a. institutional and program files, including without limitation: institutional review and Clinical Learning Environment Review Program information; program information; institution and program accreditation history; Site Visit Reports; progress reports; Case Log data; survey data; and records of Committee consideration;

b. appeals files;

c. additional documents and correspondence recording accreditation actions and consideration thereof by the ACGME; and,

d. personal resident/fellow physician information, and protected health information submitted to the ACGME.

A breach of confidentiality could result in irreparable damage to the Review and Recognition Committees, the ACGME and its mission, and the public, and may result in removal of a director, committee member, or ACGME employee.

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8.00 ACGME Conduct

8.40 Confidentiality

8.41 Published Information Released through ACGME

The ACGME publishes and releases a list of Sponsoring Institutions and programs accredited by the ACGME on its website (www.acgme.org) and other media, including the following information:

a. names and addresses of Sponsoring Institutions;

b. names and addresses of major participating site(s);

c. names and addresses of designated institutional officials and program directors;

d. names and addresses of the institutional and program coordinator(s);

e. specialty and length of programs;

f. total number of resident/fellow positions;

g. institutional and program accreditation, institutional and program accreditation status, institutional and program recognition status, and effective date (current, and for the previous 10 years);

h. date of last Self-Study; and,

i. date of next Self-Study (if applicable).

Summary data and other information about Sponsoring Institutions, programs, resident/fellow physicians, or resident/fellow physician education that is not identifiable by person or organization may be published by the ACGME or in collaboration with other entities in a manner appropriate to further the quality of graduate medical education consistent with ACGME policies and the law.

Individual resident/fellow physician data may be submitted to specialty certification boards upon written or electronic authorization of the individual resident/fellow physician and programs, as appropriate.

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8.00 ACGME Conduct

8.40 Confidentiality

8.42 Confidentiality Administration

To protect confidential information, the ACGME assumes responsibility to:

a. not make copies of, disclose, discuss, describe, distribute, or disseminate in any manner whatsoever, including in any oral, written, or electronic form, any confidential information, or any part of it, that the Review or Recognition Committees receive or generate, except directly in conjunction with service to the ACGME;

b. not use such confidential information for personal or professional benefit or for any other reason, except directly in conjunction with service to the Review or Recognition Committees and/or the ACGME; and,

c. dispose of all materials and notes regarding confidential information in compliance with ACGME policies.

The confidentiality obligations continue to apply to former Review and Recognition Committee members. A former Review or Recognition Committee member may serve as a consultant to an institution or program but shall continue to maintain the confidentiality of confidential ACGME information. Such an individual may not serve as a consultant for an institution or program that has an accreditation decision pending before the ACGME in which decision, or part thereof, the former member participated as a Review or Recognition Committee member. If a former Review or Recognition Committee member, while serving as a consultant, receives information from an institution or program, the former member may discuss such information with the institution or program, if the same information was submitted to the Review or Recognition Committee. However, the former Review or Recognition Committee member may not discuss the consideration of the institution or program by the Review or Recognition Committee in which the former Review or Recognition Committee member participated or otherwise became aware by virtue of the Review or Recognition Committee membership.

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8.50 Policies Governing Review and Recognition Committee Member Conduct

Upon appointment by the ACGME Board, all Review and Recognition Committee members (except ex-officio members) must sign an agreement annually to comply with these ACGME Policies and Procedures, including those relating to fiduciary duty, conflict and duality of interest, and confidentiality. Ex-officio members must sign an agreement annually to comply with these ACGME Policies and Procedures, including those related to conflict of interest and confidentiality. These agreements shall be kept on file by the ACGME administration.

Members of a Review and Recognition Committee may not act for or on behalf of the Review and Recognition Committee or the ACGME without explicit authorization by ACGME administration. This does not preclude Review and Recognition Committee members from reporting on general Committee activities to appropriate organizations.

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8.60 Board and Review and Recognition Committee Attendance

Whenever an ACGME Director or Review or Recognition Committee member fails to attend two or more of any four consecutive regular meetings of the ACGME Board or Review or Recognition Committee, the Governance Committee shall:

a. invite the Director or Review or Recognition Committee member to submit a written explanation of any extraordinary circumstances underlying the absences; and,

b. make a recommendation to the ACGME Board as to whether it should take any action for failure of the director or Review or Recognition Committee member to attend two or more of any four consecutive meetings of the ACGME Board or Review or Recognition Committee.

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8.70 Directors' Attendance at Board Standing Committee Meetings

Subject to ACGME policy on conflicts and dualities of interest, upon invitation of a standing committee through its Chair, ACGME Directors who are not members of the standing committee may attend all or parts of a meeting of the standing committee as observers. Standing committee Chairs may exercise discretion in allowing a Board Director to speak and address agenda issues. In addition, subject to ACGME policy on conflicts and dualities of interest, the ACGME Board Chair may attend meetings of all standing committees as an ex-officio member, and public Directors have an invitation to attend meetings of all standing committees, even if they are not members of those committees.

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9.00 Financials

9.10 Fee Structure

The ACGME charges fees to defray the costs of accreditation. These fees are annually determined by the ACGME.

a. Accreditation Fee

The ACGME shall charge a yearly accreditation fee to all accredited programs. This fee covers all the costs associated with ongoing accreditation, including the following services:

- site visits;
- collection, preparation, and distribution of data;
- review of program materials;
- surveys and Case Log processing and reporting;
- selecting, organizing, and convening peer-review committees; and,
- notification of accreditation decisions.

Accreditation fees are determined by program size and are published on the ACGME website.

b. Application Fee

A non-refundable fee is charged for processing applications for new or previously withdrawn or withheld programs seeking accreditation. This fee is assessed upon receipt of the application.

c. Appeal Fee

In the event of an appeal of an adverse action, an appeal fee shall be assessed. In addition, the appellant and the ACGME shall equally share the expenses incurred by the ACGME related to the appeal.

d. Canceled or Postponed Site Visit Fee

If a program cancels or postpones a scheduled site visit, the ACGME shall charge a cancelation fee. This fee may be waived at the discretion of the Senior Vice President, Field Activities.

e. Due Date

Fees for annual accreditation are payable within 60 days of the invoice date. Fees for applications are payable within 30 days of the invoice date.

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9.00 Financials

9.20 Expenses

The ACGME defrays expenses in accordance with financial policies established annually.

a. Facilities

Charges for facilities and services associated with meetings, such as meeting rooms, food service, or special arrangements, are paid by the ACGME.

b. ACGME Board Directors and Committee Members

The ACGME shall assume responsibility for reasonable travel and lodging costs related to attendance at meetings. The ACGME will reimburse up to $125 per day for meal expenses during travel and/or meeting days.

Directors and members may not accept payment for service while on or representing the ACGME Board or any ACGME committee, including travel upgrades at the expense of the nominating organization or the ACGME, honoraria, or duplicative remuneration.

c. Ex-Officio Attendees of a Review or Recognition Committee

Ex-officio attendees of a Review or Recognition Committee shall not be reimbursed for expenses by the ACGME.

d. ACGME Staff Members

Expenses incurred by ACGME staff members shall be reimbursed by the ACGME.

e. Guests and Consultants

Guests and consultants shall be eligible for reimbursement of expenses if they are attending a meeting at the request of the ACGME Board or a Review or Recognition Committee.

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10.00 Review and Recognition Committees

The function of Review and Recognition Committees (hereafter referred to as "committees" limited to this policy) is to set accreditation or recognition standards (i.e., requirements) and to provide peer evaluation of Sponsoring Institutions or residency and fellowship programs. The purpose of the evaluation is to assess whether a Sponsoring Institution or program is in substantial compliance with the applicable Institutional, Program, and/or Recognition Requirements, and to confer an accreditation or recognition status.

10.10 ACGME Delegation of Authority to Review and Recognition Committees

The responsibility for the accreditation and recognition of Sponsoring Institutions and programs in graduate medical education resides with the ACGME Board, which may delegate responsibility for accreditation and recognition to the committees. Article XI, Section 2, d) of the ACGME Bylaws states:

> "Upon application of a Review Committee or a Recognition Committee, and following a review of its performance, the Board of Directors may delegate accreditation and/or recognition authority to the Review or Recognition Committee. Such delegation shall be for a period to be determined by the Board of Directors. The Board of Directors shall conduct periodic reviews of the accreditation and recognition process of the Review and Recognition Committee and of its authority to accredit and recognize."

The ACGME Board provides oversight of the committees through the Monitoring Committee. If the Monitoring Committee recommends, and the ACGME Board approves, withdrawal of delegated accreditation or recognition authority, at the same time, the ACGME Board will also adopt a plan for uninterrupted accreditation or recognition of the affected Sponsoring Institutions and/or programs.

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10.20 Committee Membership

10.21 Member Qualifications

At the time of appointment, committee members, with the exception of the resident/fellow and public member, should be actively involved in graduate medical education; demonstrate substantial experience in administration and/or a Sponsoring Institution or program with an ACGME accreditation or recognition status, as applicable, other than warning or probation. Additional qualifications may be identified by each committee as appropriate.

Committee members, with the exception of the resident/fellow member and the public member, must have appropriate certification through a member board of the American Board of Medical Specialties or a certifying board of the American Osteopathic Association, or have other qualifications acceptable to the Committee.

10.22 Member Nomination and Appointment

The ACGME Board establishes Review and Recognition Committee complement based on recommendations from the ACGME administration regarding the total number and distribution of committee member positions among nominating organizations.

Review Committee nominating organizations may be changed or deleted upon unanimous recommendation of the existing nominating organizations for that Review Committee and approval by the ACGME Board.

Each Committee solicits nominations from nominating organizations approved by the ACGME Board, the public, and/or the graduate medical education community.

Committees soliciting nominations should do so with sufficient notice to allow a nominating organization to identify and submit the names of at least two candidates for each vacancy to the committee's Executive Director at least 12 months before the date of the appointment. Committees should solicit and consider candidates consistent with Policy 3.00 and shall not consider nominees from same institutions or city/metropolitan area of current membership at the time of appointment.

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10.00 Review and Recognition Committees

10.20 Committee Membership

10.23 Committee Member Terms

All members of a committee have full voting rights and may participate and vote on all matters, subject to the ACGME policy regarding conflicts and dualities of interest (Policy 8.20). With the exception of the resident/fellow member, committee members shall be appointed to six-year terms. Upon completion of a six-year term, a member may not be appointed again to the same committee.

The term of the resident/fellow member is two years. Upon completion of the term, the resident/fellow member may not be appointed again to the same committee as a resident/fellow member. However, the resident/fellow member may serve as Chair of the Council of Review Committee Residents even if the term as Chair continues after the individual has left the Review or Recognition Committee.

10.24 Member Responsibilities

Each committee member must:

a. participate in an orientation before reviewing Sponsoring Institutions or programs;

b. adhere to ACGME policies and procedures;

c. attend meetings (Policy 8.60);

   Whenever a committee member fails to attend two or more of any four consecutive regular meetings, the ACGME Governance Committee shall:

   1. invite the member to submit a written explanation of any extraordinary circumstances underlying the absences; and,

   2. make a recommendation to the ACGME Board as to whether it should take any action for failure of the member to attend two or more of any four consecutive meetings.

d. agree to and perform the tasks associated with membership; and,

e. be evaluated on performance by other members of the committee and appropriate ACGME staff members.

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10.00 Review and Recognition Committees

10.20 Committee Membership

10.25 Removal of Committee Members

a. Reasons for Removal

Consistent with Article IX, Section 6 of the ACGME Bylaws, a committee member may be removed by a majority vote of the ACGME Board when, in the judgment of the Board, the best interests of the ACGME would be served. This may include, but is not limited to, the following:

1. failure of the member to perform committee responsibilities appropriately, violation of rules of confidentiality, an unreconcilable conflict of interest that occurs after appointment, or routine failure to attend meetings; and/or

2. unprofessional, illegal, or unethical conduct detrimental to the ACGME, including conduct that occurs outside of the member's responsibilities with the committee.

b. Process for Removal

In removing a committee member, the following procedures shall apply:

1. The President and Chief Executive Officer of the ACGME shall provide the committee member in question with written notice of the proposed removal, which must include an explanation of the reason for the proposed removal. The committee member shall be given an opportunity to provide a written response to the allegation.

2. If the allegation is deemed to warrant removal of the committee member, the President and Chief Executive Officer of the ACGME shall present the information and a recommendation to the ACGME Executive Committee.

3. The committee member shall be given the opportunity to appear before the ACGME Executive Committee.

4. The recommendation of the ACGME Executive Committee shall be presented for action to the ACGME Board at its next meeting. During this process, the committee member in question may not attend committee meetings. The decision of the ACGME Board is final and not subject to appeal.

5. The action and rationale of the ACGME Board shall be communicated by the President and Chief Executive Officer of the ACGME to the committee member. The action shall be communicated to the nominating organization, the Executive Director and Chair of the committee (or the Vice Chair if the committee member in question is the Chair). The details of the action shall be considered confidential and shall not be otherwise shared.

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10.30 Committee Structure

10.31 Committee Size

The ACGME Board shall determine the number of members of each committee based on the overall workload, including the number of Sponsoring Institutions or programs under the committee's purview. Requests for changes in the number of members of a committee must be submitted to the ACGME President and Chief Executive Officer and are subject to approval by the ACGME Board.

10.32 Committee Composition

a. Committee Chair

1. Each committee Chair shall be elected from the membership of the committee for a three-year term and shall not be eligible for re-election upon conclusion of that term. If the Chair for any reason relinquishes the position prior to the completion of the term, the committee shall elect a new Chair. If a committee member is elected Chair with only two years remaining in the member's six-year committee term, that term may be extended by one year to fulfill the three-year term as Chair.

2. Each committee Chair shall call and preside over meetings of the committee. The Chair shall ensure that the committee discharges its responsibilities in accordance with ACGME policies and procedures. The Chair shall attend the meetings of the ACGME Council of Review Committee Chairs.

b. Committee Vice Chair

1. The Vice Chair should be elected by the committee for a term of two years, which may be extended.

2. In the Chair's absence, the committee's Vice Chair shall assume the duties of the Chair.

c. Resident/Fellow Member

Each committee must include at least one resident or fellow. The resident/fellow member must be enrolled in an ACGME-accredited residency or fellowship program at the time of appointment and at the time of any extension of appointment.

d. Public Member

Each committee must include at least one public member.

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10.00 Review and Recognition Committees

10.30 Committee Structure

10.32 Committee Composition

e. Other Committee Meeting Attendees

1. Ex-Officio

Each nominating organization may appoint one representative to attend regularly scheduled committee meetings without vote (ex-officio).

Ex-officio attendees are subject to the same rules of conflict and duality of interest and confidentiality as voting members. Ex-officio attendees may attend regularly scheduled committee meeting but shall not participate in institution or program review nor have access to institution or program review materials. Ex-officio attendees may participate only in the business portion of the agenda.

A nominating organization that engages in consulting to graduate medical education programs:

a) may send a person to attend regularly scheduled committee meetings in an ex-officio capacity, but that person, while serving in that capacity, shall not (1) serve as an institutional or program consultant in graduate medical education, or (2) have any responsibility for such consulting, including without limitation, being a person to whom any such consultant reports directly or indirectly as a matter of that individual's employment or as a volunteer;

b) may not advertise in connection with its consulting to graduate medical education institutions or programs that a person appointed by the nominating organization is an ex-officio attendee of the committee; and,

c) shall provide evidence to the ACGME of the steps taken by the nominating organization to ensure that:

i. it follows (a) and (b) immediately above;

ii. the ex-officio appointed by it complies with ACGME conflict and duality of interest and confidentiality policies; and,

iii. any information (confidential or otherwise) learned by its appointed ex-officio attendee is not transferred to anyone within the nominating organization having any responsibility for consulting with graduate medical education institutions or programs.

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10.00 Review and Recognition Committees

10.30 Committee Structure

10.32 Committee Composition

2. Staff Members, Consultants, and Guests

   a) Staff members, consultants, and guests are subject to the ACGME policies related to conflict and duality of interest and confidentiality.

   b) During institutional/program review, staff members, consultants, and guests may provide information or clarification for matters related to Sponsoring Institutions and programs under review but may not participate in Sponsoring Institution and program accreditation or recognition decisions.

   c) On occasion, ACGME Board Directors may attend Committee meetings. These directors may observe Sponsoring Institution or program review and policy discussions but may not participate in Sponsoring Institution or program review discussion or accreditation/recognition decisions.

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10.40 Review Committee Responsibilities

Each Review Committee functions under accreditation authority delegated by the ACGME Board.

Review Committees shall:

a. accredit Sponsoring Institutions and/or programs consistent with established ACGME policies and procedures using the Institutional and Program Requirements, as applicable;

b. confer an accreditation status for each Sponsoring Institution or program being evaluated, subject to appeal of adverse actions to the ACGME Board;

c. prepare, revise, and/or recommend, institutional and/or program requirements to reflect current educational and clinical practice; and participate in preparation and/or revision of and/or comment on the Common Program Requirements; and,

d. initiate discussion in matters of policy, best practice, and innovation relating to graduate medical education.

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10.40 Recognition Committee Responsibilities

Each Recognition Committee functions under recognition authority delegated by the ACGME Board.

Recognition Committees shall:

a. prepare, revise, and recommend to the ACGME Board standards (recognition requirements) with which Sponsoring Institutions and/or programs must substantially comply to be conferred recognition;

b. review and evaluate Sponsoring Institutions and/or programs for substantial compliance with these standards; and,

c. confer a recognition status on each Sponsoring Institution and/or program that seeks or seeks to maintain recognition, and that complies substantially with the Recognition Requirements, subject to appeal of adverse actions to the ACGME Board.

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10.50 Conduct of Committee Meetings

Committee meetings should be conducted as follows:

a. Committees shall meet at regularly prescribed intervals to conduct business. The length and frequency of meetings should be determined by workload. Any additional meetings or extended meetings require prior administrative approval.

b. A simple majority of the voting members must be present for all policy and accreditation/recognition decisions.

c. During deliberations and conduct of business, committee members must function in a manner consistent with the ACGME policies and procedures regarding fiduciary duty, conflict and duality of interest, and confidentiality (Policies 8.10-8.40).

d. All accreditation-/recognition-related actions must comply with ACGME policies and procedures.

e. ACGME Committee staff members shall record meeting minutes, including the accreditation/recognition actions taken.

f. A committee may conduct a regular or special meeting by telephone conference or interactive technology by means of which all persons participating in the meeting can communicate with each other.

g. When circumstances cause a committee to reschedule a confirmed meeting for reasons such as inclement weather, a national emergency, or other emergency situation, relevant staff members will follow the procedures outlined in the ACGME's Meeting Cancellation Policy.

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10.60 Advisory Committees

a. A Review Committee may have one or more temporary advisory committees to:

   1. review applications for accreditation for programs in a new specialty or subspecialty and make recommendations to the Review Committee relating to the applications or portions thereof;

   2. assist the Review Committee in developing the Program Requirements for a new specialty or subspecialty; and/or,

   3. to perform other functions.

b. An advisory committee to review applications for accreditation may be established upon request by a Review Committee and approval by the ACGME Board. The request shall include at least:

   1. the function(s) of the advisory committee;

   2. the rationale for establishing the advisory committee;

   3. the estimated duration of the advisory committee's tenure;

   4. the expertise of the members of the advisory committee, and,

   5. the number of members of the advisory committee.

c. Members of an advisory committee shall have the same confidentiality, conflicts/duality, and fiduciary responsibilities to the ACGME as do Review Committee members.

d. Members of an advisory committee to review applications shall be nominated by the Review Committee consistent with Policy 3.00 and appointed by the ACGME Board. Other advisory committees may be established upon approval of the ACGME President and Chief Executive Officer.

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11.00 Procedures for Development and Approval of Requirements

11.10 New or Revised Requirements

ACGME committees must submit proposed new or revised institutional, program, or recognition requirements to the ACGME Committee on Requirements. Proposed requirements must be reviewed by the Vice President, Accreditation Standards, after which the Committee on Requirements shall review and make recommendations to the ACGME Board on the approval of the proposed new or revised requirements, pursuant to Policy 11.20.

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11.20 Revisions of Requirements

Prior to drafting major revisions to existing requirements, all ACGME committees must solicit input on the requirements currently in effect from the community of interest and the public through the ACGME website and other communication channels, as appropriate.

a. After consideration of the comments received, the applicable committee shall complete the revisions in the format required by the ACGME, including preparation of a complementary Rationale Statement.

b. New Requirements, and major or interim revisions to existing Requirements, must be subject to public review and comment. The proposed revised Requirements document and the Rationale Statement shall be posted on the ACGME website. A 45-day period of public comment shall commence upon notification of the community of interest, including the public.

   1. ACGME Board Directors and committee members shall not provide written comments on the proposed new or revised requirements individually or on behalf of their programs (if applicable), institutions, or other organizations, except that:

      a) committee Chairs may submit written comments on behalf of their committee; and,

      b) a committee whose Chair is an ACGME Board Director shall submit that committee's comments through its Vice Chair.

   2. Requirements must be reviewed every 10 years. If a committee deems that no revisions are necessary, the existing Requirements document must still be posted for public comment. If no comments are received, a letter explicitly stating that the review has been accomplished and that no revisions are required must be submitted by the committee to the Committee on Requirements.

   3. Interim revisions may be considered at scheduled intervals between major requirement revisions, which will typically be every three years. On rare occasions, upon the recommendation of a committee to the administration of the ACGME, or otherwise from the administration of the ACGME, and with the approval of the ACGME Board, revisions may be considered between these scheduled intervals.

c. Comments shall be evaluated by the committee, and that committee shall determine which suggestions will be incorporated into the proposed new or revised Requirements for submission to the Committee on Requirements. The committee shall submit all comments received, along with their responses, to the Committee on Requirements, together with the proposed new or revised Requirements document.

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11.00 Procedures for Development and Approval of Requirements

11.20 Requirements Revisions

d. The review of proposed new or revised Requirements documents shall occur at a meeting of the Committee on Requirements, whose recommendations shall be forwarded to the ACGME Board for action.

e. The typical effective date for revisions shall be July 1 as approved by the ACGME Board. The ACGME Board shall consider the recommendation of the relevant committee for the effective date of implementation of new or revised Requirements. The effective date must provide sufficient time for institutions or programs to implement changes.

f. On initial approval of new Requirements, the effective date will be the date on which the requirements are approved by the ACGME Board unless otherwise indicated by the ACGME Board. The ACGME Board shall consider a recommendation of a committee as to the effective date.

11.30 Rationale and Impact Statement for Proposed Requirements

The ACGME committee proposing requirements must prepare a statement describing the rationale for each substantial change and the anticipated impact of the proposed requirements on patient care, resident/fellow education, other accredited programs, and/or the allocation of resources within a Sponsoring Institution. At the time of the required 45-day review and comment period, this rationale and impact statement will accompany the proposed Requirements document when it is posted for public comment to actively solicit input related to the impact of each of the proposed requirements. The committee shall consider this information in finalizing the Requirements.

11.40 Editorial Revisions of Existing Requirements

After approval by the ACGME Board, Requirements documents shall be edited by the ACGME Editorial Services staff before they are posted on the ACGME website. Any such editing shall not substantively change approved requirements.

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11.50 Revisions to the Common Program Requirements

The ACGME Board has responsibility for oversight of the Common Program Requirements. The ACGME Council of Review Committee Chairs shall participate in the process of revising the Common Program Requirements. Proposed revisions to the Common Program Requirements may be submitted by any program director, resident, fellow, Review Committee, designated institutional official, ACGME Member Organization, nominating organization, the ACGME Board, or the public.

Major revisions to the Common Program Requirements shall occur every 10 years. Interim revisions may be considered at scheduled intervals between major revisions, which will typically be every three years. On rare occasions, upon the recommendation of the administration of the ACGME and as directed by the ACGME Board, revisions may be considered between these scheduled intervals.

Revisions to the Common Program Requirements shall be conducted by a committee convened by the ACGME Board and composed of members of the ACGME Board and the Council Review Committee Chairs. At the recommendation of the President and Chief Executive Officer of the ACGME and the approval of the Executive Committee of the ACGME Board, the ACGME administration may propose draft language for consideration by this committee. The committee shall:

a. request comments from ACGME Member Organizations, the committees, nominating organizations, standing committees and Councils of the ACGME Board, program directors, designated institutional officials, and the public;

b. revise or develop a draft of the revised Common Program Requirements;

c. post the draft on the ACGME website for a 45-day public comment period;

d. request comment on the draft by the Council of Review Committee Chairs; and,

e. review the comments of the Council of Review Committee Chairs, together with all comments received, make revisions to the draft, and submit the proposed revised Common Program Requirements and a recommended effective date to the Committee on Requirements.

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11.60 Waivers to the Common Program Requirements for Multi-Center Educational Research Trials

The ACGME Board may review and approve requests for waivers to the Common Program Requirements to permit the conduct of multi-center educational research trials designed to answer questions fundamental to development or modification of the Common Program Requirements. Such proposals must first gain approval of the involved specialty Review Committee(s) and the administration of the ACGME.

Decisions of the ACGME Board related to multi-center educational research trials are final. There is no appeal of these decisions.

11.70 Procedures for Developing Program Requirements for Specialties Using a Common Set of Program Requirements in a Multidisciplinary Subspecialty

The ACGME administration shall appoint an ad hoc committee to include representatives of the specialties participating in a new multidisciplinary subspecialty. The relevant Review Committees shall agree to adhere to one set of Program Requirements. For subsequent revisions of the Program Requirements, the relevant Review Committees must reach agreement on the revisions. The requirements submitted to the Committee on Requirements must represent the consensus of all participating Review Committees.

If the Review Committees are unable to reach consensus on one or more of the requirements, the Committee on Requirements will encourage the involved parties to articulate the issues at hand. The Committee on Requirements shall review all available information, including comments by interested parties and the community of interest, and shall have the opportunity to ask questions and seek additional information. The Committee on Requirements shall make a recommendation to the ACGME Board on the Program Requirements after considering all information that it judges relevant and appropriate.

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12.00 Procedures for Accreditation Designation of Specialties, Subspecialties, and Sub-Subspecialties

The ACGME Board shall evaluate proposals and determine whether the ACGME will accredit programs in a new specialty, subspecialty, or sub-subspecialty. If approved, the ACGME Board will either establish a new Review Committee, or delegate accreditation authority to one or more existing Review Committees.

Combining resident/fellow education in two or more specialties does not constitute, in and of itself, the creation of a new specialty, subspecialty, or sub-subspecialty for the purpose of designation.

12.10 Criteria for Designation of a Specialty for which Accreditation Will Be Offered

The proposal for accreditation designation in a new specialty shall be sent to the President and Chief Executive Officer of the ACGME.

Proposals for designation of a new specialty for which accreditation will be offered must provide evidence, at minimum, that the specialty:

a. demonstrates that the clinical care of patients and safety will be improved through accreditation designation of education in the discipline;

b. is sufficiently distinct from other specialties based on major new concepts in medicine and the delivery of patient care;

c. represents a new and well-defined field of medical practice;

d. is based on substantial advancement in medical science;

e. offers educational content that cannot be incorporated within established specialty residency programs;

f. will generate sufficient interest and resources to establish the critical mass of quality residency programs with long-term commitment for successful integration of the graduates in the health care system nationally;

g. at a minimum, maintains at least 50 active programs and 200 residents nationally;

h. is recognized as the single pathway to the competent preparation of a physician in the new specialty; and,

i. has one or more national medical societies with a principal interest in the proposed specialty.

Upon receipt of a proposal for accreditation designation of a new specialty, the proposal will be posted on the ACGME website for a 45-day period of public review and comment.

12.20 Criteria for Designation of a Subspecialty or Sub-Subspecialty for which Accreditation Will Be Offered

The ACGME accredits programs in subspecialties and sub-subspecialties when it can be demonstrated that the clinical care of patients and their safety will be improved through accreditation of the educational program in the discipline.

Proposals for designation of a new subspecialty or sub-subspecialty for which accreditation is being sought shall be submitted to the President and Chief Executive Officer of the ACGME. These proposals must provide documentation on the professional and scientific status of the new subspecialty or sub-subspecialty, including at minimum, evidence of the following:

a. the clinical care and safety of patients will be improved through the accreditation of subspecialty or sub-subspecialty programs in the discipline;

b. the existence of a body of scientific medical knowledge underlying the subspecialty or sub-subspecialty that is:

    1. clinically distinct from other areas in which accreditation is already offered; and,

    2. sufficient for educating individuals in a clinical field, and not simply in one or more techniques.

c. the existence of a sufficiently large group of physicians who concentrate their practice in the proposed subspecialty or sub-subspecialty;

d. the existence of national medical societies with a principal interest in the proposed subspecialty or sub-subspecialty;

e. the regular presence in academic units and health care organizations of educational programs, research activities, and clinical services such that the subspecialty or sub-subspecialty is broadly available nationally;

f. a projected number of programs sufficient to ensure that ACGME accreditation is an effective method for quality evaluation, including current and projected numbers for each participating specialty if the subspecialty is multidisciplinary;

g. the duration of the subspecialty or sub-subspecialty program is at least one year beyond education in the associated specialty; and,

h. a primarily clinically based educational program.

Upon receipt of a proposal for designation of a new subspecialty or sub-subspecialty, the proposal will be posted on the ACGME website for a 45-day period of public review and comment.

12.00 Procedures for Accreditation Designation of Specialties, Subspecialties, and Sub-Subspecialties

12.20 Criteria for Designation of a Subspecialty or Sub-Subspecialty for which Accreditation Will Be Offered

If the subspecialty or sub-subspecialty is multidisciplinary, the ACGME Board will designate the Review Committees that will review programs in the subspecialty or sub-subspecialty based on the projected numbers of programs by specialty and in accordance with Policy 12.20. For participating specialties not expected to reach a threshold of five programs within five years, programs must apply for accreditation to one of the designated Review Committees. If at any time in the future, there are five or more programs from a participating specialty that is not a designated Review Committee, that specialty Review Committee may be newly designated to review programs in that subspecialty or sub-subspecialty.

12.30 Criteria for Designation of a Sponsoring Institution-Based Fellowship for Which Accreditation Will Be Offered

Sponsoring Institution-based fellowships are designated as fellowships for which accreditation will be offered upon the ACGME's strategic recognition of health care and population health needs that are not being fully met through current specialty-based graduate medical education accreditation.

The ACGME accredits Sponsoring Institution-based fellowships when it can be demonstrated that the clinical care of patients and their safety will be improved through accreditation of the educational program. Sponsoring Institution-based fellowship programs provide educational experiences that promote the integration of clinical, administrative, and leadership competencies that address the broad healthcare needs in the United States.

Proposals for designation of new Sponsoring Institution-based fellowships for which accreditation will be offered shall be submitted to the President and Chief Executive Officer of the ACGME. These proposals must provide documentation on the professional and scientific status of the new Sponsoring Institution-based fellowship, including, at a minimum, evidence of the following:

a. the clinical care and safety of patients and populations will be improved through the designation of the proposed fellowship;

b. the existence of a body of knowledge underlying the proposed fellowship that is (i) distinct from other areas in which accreditation is already offered, and (ii) sufficient for providing educational experiences that promote the integration of clinical, administrative, and leadership competencies that address the broad system-based needs of health care environments;

c. the existence and/or need for a sufficiently large group of physicians to apply the knowledge and skills of the proposed fellowship in their healthcare environments;

d. the existence of national medical or medical-related societies with substantial physician membership, and with a principal interest in the proposed fellowship;

e. the presence in academic units or health care organizations of educational programs and research activities such that there is national interest in establishing fellowship programs;

12.00 Procedures for Accreditation Designation of Specialties, Subspecialties, and Sub-Subspecialties

f. a projected number of programs sufficient to ensure that ACGME accreditation is an effective method for quality evaluation, including current and projected numbers of fellowship programs;

12.30 Criteria for Designation of a Sponsoring Institution-Based Fellowship for Which Accreditation Will Be Offered

g. the duration of the Sponsoring Institution-based fellowship programs is at least one year;

h. Physicians who have completed a residency program in a core specialty designated for accreditation by ACGME are eligible to enter Sponsoring Institution based fellowships; and,

i. the educational program of the fellowship is primarily experiential.

Upon receipt of a proposal for designation of a new Sponsoring Institution-based fellowship, the proposal will be posted on the ACGME website for a 45-day period of public comment.

The ACGME Board may designate the Institutional Review Committee or a newly appointed Review Committee to review Sponsoring Institution-based fellowship programs.

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13.00 Procedures for Designation of a Medical or Medical-Related Specialty that is not a Core Specialty, Subspecialty, or Sub-Subspecialty for which Accreditation Will Be Offered

a. The ACGME Board shall evaluate proposals for the accreditation of post-doctoral educational programs in a medical or medical-related specialty.

b. The ACGME Board shall determine whether the ACGME will:

   1. accredit post-doctoral educational programs in a medical or medical-related specialty; and,

   2. establish a new Review Committee or delegate accreditation authority to an existing Review Committee.

13.10 Criteria for Designation of a Medical or Medical-Related Specialty that is not a Core Specialty, Subspecialty, or Sub-Subspecialty for which Accreditation Will Be Offered

Proposals for designation of a medical or medical-related specialty for which accreditation will be offered must include, at a minimum, evidence of the following:

a. the medical or medical-related specialty is a clinical care-related specialty in which physicians may participate;

b. the medical or medical-related specialty supports the clinical practice of medicine;

c. physicians or others with terminal degrees, are eligible to participate in the post-doctoral medical education program, but physicians are not required to have full medical licenses or training licenses to participate;

d. participation in the post-doctoral medical education program by physicians would not qualify toward satisfaction of the residency requirement for medical licensure;

e. there is a body of scientific medical knowledge underlying the medical or medical-related specialty that is clinically distinct from other areas for which ACGME accreditation is already offered;

f. the medical or medical-related specialty represents a well-defined field of medical practice;

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13.00 Procedures for Designation of a Medical or Medical-Related Specialty that is not a Core Specialty, Subspecialty, or Sub-Subspecialty for which Accreditation Will Be Offered

13.10 Criteria for Designation of a Medical or Medical-Related Specialty that is not a Core Specialty, Subspecialty, or Sub-Subspecialty for which Accreditation Will Be Offered

g. the medical or medical-related specialty is based on widely accepted scientific principles;

h. the programs offer educational content that is separate from residency or fellowship education and training;

i. there is a sufficiently large number of individuals who concentrate their work in the medical or medical-related specialty;

j. there is ongoing research and scientific discovery that advances the medical or medical-related specialty;

k. the projected number of programs is sufficient to ensure that ACGME accreditation is an effective method for quality evaluation;

l. there is one or more national professional societies with a principal interest in the medical or medical-related specialty;

m. the duration of the educational program is at least one year; and,

n. the educational program is primarily clinically related.

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14.00 Monitoring the Designation of Specialties, Subspecialties, Sub-Subspecialties, and Medical or Medical-Related Specialties

When the ACGME decides to designate a specialty, subspecialty, sub-subspecialty, medical or medical-related specialty, or sponsoring institution-based fellowship for which accreditation will be offered, the decision shall be provisional for a period of up to five years following the year that the first program applying for accreditation achieved Initial Accreditation. At the end of the provisional period, the Monitoring Committee shall review data relevant to accreditation of programs in the specialty, subspecialty, sub-subspecialty, medical or medical-related specialty, or Sponsoring Institution-based fellowship using, as applicable, criteria for the designation of a specialty as specified in Policy 12.10, criteria for designation of a subspecialty or sub-subspecialty as specified in Policy 12.20, criteria for designation of a Sponsoring Institution-based fellowship as specified in Policy 12.30, or criteria for designation of a medical or medical-related specialty as specified in Policy 13.10 of this document.

If these data do not support the continued accreditation of programs in the specialty, subspecialty, sub-subspecialty, medical or medical-related specialty, or Sponsoring Institution-based fellowship, the Monitoring Committee may recommend discontinuing ACGME accreditation of the specialty, subspecialty, sub-subspecialty, medical or medical-related specialty, or Sponsoring Institution-based fellowship. If a decision to discontinue accreditation of a specialty, subspecialty, sub-subspecialty, or medical or medical-related specialty is made, the ACGME shall follow its procedures for discontinuing accreditation of programs as defined in the responsibilities of the Monitoring Committee (Policy 6.63).

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15.00 Procedures for Review Committees to Accredit the Same Subspecialty

15.10 Multidisciplinary Subspecialties

A multidisciplinary subspecialty is one in which programs may be reviewed for accreditation status by multiple Review Committees.

One set of Program Requirements for the subspecialty shall apply to all programs regardless of the Review Committee to which a program submits an application for accreditation. The interpretation of the Program Requirements represents and reflects a unique specialty approach to the care of patients and the education of fellows in each subspecialty.

Each of the Review Committees involved in accreditation of the subspecialty may accept or reject eligibility exceptions for all the subspecialty programs it accredits, as provided in Common Program Requirement III.A.1. (effective July 1, 2019).

15.20 Review Committee Requests to Join Accredited Multidisciplinary Subspecialty

Requests to add an accrediting Review Committee to a currently accredited multidisciplinary subspecialty must be submitted to the President and Chief Executive Officer of the ACGME and must address the following:

a. the existence of a sufficiently large group of physicians in the specialty who concentrate their practice in the multidisciplinary subspecialty;

b. information regarding opportunities for board certification in the multidisciplinary subspecialty;

c. documentation outlining how the specialty adequately prepares its graduates, in a similar manner to the existing accrediting Review Committee, for the multidisciplinary subspecialty; and,

d. a projected number of programs in the subspecialty expected to apply for accreditation to the Review Committee seeking designation as an accrediting Review Committee.

Prior to a determination by the ACGME Board, comments regarding the proposal shall be solicited from the existing accrediting Review Committees of the multidisciplinary subspecialty, and the proposal will be posted on the ACGME website for a 45-day period of public comment. The ACGME Board shall then evaluate the proposal and all relevant comments and determine whether to approve the specialty as an accrediting Review Committee of the existing accredited multidisciplinary subspecialty.

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15.30 Requests for a New Eligibility Pathway for Appointment to a Multidisciplinary Fellowship Program

Requests to designate graduates of a specialty program as eligible for appointment to a fellowship program in the multidisciplinary subspecialty must be submitted to the Vice President, Accreditation Standards and the Chair of the Committee on Requirements, and must address the following:

a. information regarding opportunities for board certification in the multidisciplinary subspecialty for individuals who complete residency education in the requested specialty; and,

b. documentation outlining how the specialty adequately prepares its graduates, in a similar manner to the existing sponsoring specialties, for the multidisciplinary subspecialty.

The Vice President, Accreditation Standards shall forward the request to each Review Committee that accredits programs in the subspecialty. If all the applicable Review Committees approve the proposal, the subspecialty Program Requirements shall be revised accordingly, subject to the process for review and approval of Program Requirements, as outlined in Policy 11.00.

If one or more of the Review Committees that accredits programs in the subspecialty does not approve the proposal, it shall document its concerns in writing. The request, along with the written comments from the accrediting Review Committee(s), shall then be forwarded to the Committee on Requirements for resolution of an inter-specialty conflict. The Committee on Requirements shall review all available information, including comments by interested parties, and shall have the opportunity to ask questions and seek additional information. The Committee on Requirements shall make a recommendation to the ACGME Board to approve or deny the request after considering all information deemed relevant and appropriate.

If the Board approves the request, the Program Requirements shall be revised to grant eligibility for appointment to programs in the subspecialty to graduates of programs in the requesting specialty, subject to the process for review and approval of Program Requirements, as outlined in Policy 11.00.

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Accreditation/Recognition Policies and Procedures

16.00 Sponsoring Institutions and Types of Graduate Medical Education Programs

a. Sponsoring Institutions

Sponsoring Institutions oversee and provide assurance for the quality of the learning and working environment in all their ACGME-accredited programs, including all participating sites. Each Sponsoring Institution must achieve and maintain institutional accreditation before any of its sponsored programs can be accredited by the ACGME.

1. Change of Sponsorship

Transfer of institutional sponsorship of an ACGME-accredited program to another ACGME-accredited Sponsoring Institution requires the designated institutional official (DIO) and senior administrative official of the original Sponsoring Institution to indicate willingness to give up sponsorship, and the DIO and senior administrative official of the receiving Sponsoring Institution, to indicate willingness to accept institutional sponsorship. The transferring and receiving sponsors shall indicate their approval in the Accreditation Data System (ADS). The change must be initiated in ADS by the transferring sponsor. Both the transferring and receiving Sponsoring Institutions must have current ACGME accreditation. Dependent fellowship programs may not be transferred without a specified relationship to an appropriate program in the receiving Sponsoring Institution or an exception granted by a Review Committee. Review and Recognition Committees may request additional information in support of any request to transfer institutional sponsorship.

b. Categories of ACGME-Accredited Graduate Medical Education Programs

Each ACGME-accredited graduate medical education program must be sponsored by an ACGME-accredited Sponsoring Institution.

1. Residency Programs (i.e., core, specialty)

A residency program is 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 medical school as described in the ACGME Institutional Requirements; and,

b) residency programs available for physician admission after completion of prerequisite clinical education as described in the relevant specialty-specific Program Requirements.

2. Fellowship Programs (i.e., subspecialty, sub-subspecialty)

A fellowship program provides advanced education and training in progressive levels of specialization following completion of education and training in a primary specialty. 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.

There are two types of affiliations for fellowship programs: residency-dependent and residency-independent. Programs within a subspecialty must be one of these two types, as determined by the Review Committee. A Review Committee may determine that all programs accredited in a particular subspecialty:

a) must be dependent without exception; or

b) should be dependent, except that a Review Committee may grant exceptions on a program-by-program basis.

3. Combined Programs

a) Shortened program length: A program that provides residents/fellows with education and training in two or more specialties/subspecialties, with a shorter length of training than completion of each program independently. Completion of such a program should result in eligibility to take the certification examination in each relevant specialty/subspecialty offered by member boards of the American Board of Medical Specialties and/or certifying boards of the American Osteopathic Association.

b) Standard program length: A program that provides residents/fellows with education and training in two or more specialties/subspecialties, with no reduction in overall length of training. Completion of such a program should result in eligibility to take the certification examinations in each relevant specialty/subspecialty offered by member boards of the American Board of Medical Specialties and/or certifying boards of the American Osteopathic Association.

4. Dependent Subspecialty Programs

These programs are required to function with an accredited residency program in the related specialty. The accreditation of the subspecialty program is dependent on the residency program maintaining its accreditation. The residency-dependent subspecialty program must be sponsored by the same ACGME-accredited Sponsoring Institution.

5. Independent Subspecialty Programs

These programs are not required to function with an accredited residency program in the related specialty and are instead dependent on an ACGME-accredited Sponsoring Institution. These programs may occur in two circumstances.

a) The first circumstance is one which is reliant upon an ACGME-accredited Sponsoring Institution that sponsors programs in more than one specialty and/or subspecialties.

b) The second circumstance is one which is reliant upon an ACGME-accredited Sponsoring Institution that sponsors a program or programs in only one subspecialty.

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6. Sub-Subspecialty Fellowship Program

   A sub-subspecialty fellowship program provides advanced education and 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.

7. Transitional Year Programs

   A transitional year program is a one-year educational experience in graduate medical education, which is structured to provide a program of multiple clinical disciplines designed to facilitate the choice of and/or preparation for entry into a specialty program. The transitional year is only a prerequisite; it does not comprise a complete specialty program in graduate medical education.

8. Programs in a Medical or Medical-Related Specialty

   A post-doctoral education program in a medical or medical-related specialty is a structured educational activity comprising a series of clinical and/or other learning experiences, designed to prepare physicians for practice in that specialty. See Policy 13.10.

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17.00 Clinical Learning Environment Review Program

17.10 Overview

The ACGME's Clinical Learning Environment Review (CLER) Program provides the profession and the public a broad view of Sponsoring Institutions' initiatives to enhance the safety of the learning environment and determine how residents and fellows are engaged in patient safety and quality improvement activities. The CLER Program consists of regular site visits to the clinical sites of Sponsoring Institutions that host ACGME-accredited residency and fellowship programs to assess graduate medical education engagement in the CLER Focus Areas of patient safety, quality improvement, supervision, well-being, teaming, and institutional efforts related to professionalism.

The underlying principle of the CLER Program is that safe, effective, professional health care learning environments are necessary to prepare residents and fellows to be safe, effective, professional health care practitioners.

The aims of the CLER Program are to:

a. support national efforts addressing patient safety;

b. increase resident and fellow knowledge of and participation in patient safety activities;

c. reinforce the proposition that an enhanced patient safety program in graduate medical education programs will increase residents' and fellows' knowledge of and participation in ongoing quality improvement activities; and,

d. monitor a Sponsoring Institution's maintenance of a learning environment that promotes and advances appropriate supervision, well-being, teaming, and the institution's support of professionalism throughout all its residency and fellowship programs.

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17.20 CLER Focus Areas

The CLER Program assesses Sponsoring Institutions in the following six CLER Focus Areas:

a. Patient Safety – including opportunities by residents and fellows to report errors, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.

b. Quality Improvement – including how Sponsoring Institutions engage residents and fellows in the use of data to improve systems of care, reduce health care disparities, and improve patient outcomes.

c. Teaming – including interprofessional learning and interprofessional collaborative practice; teaming with patients; and system supports of teaming.

d. Supervision – including how Sponsoring Institutions maintain and oversee policies of supervision concordant with ACGME requirements in an environment at both the institutional and program level that ensures the absence of retribution.

e. Well-Being – including fatigue management and mitigation; burnout; work/life balance; and addressing those at risk of or demonstrating self-harm.

f. Professionalism – including how Sponsoring Institutions educate for professionalism; monitor behavior on the part of residents, fellows, and faculty members; and respond to issues concerning:

    1. accurate reporting of program information;

    2. integrity in fulfilling educational and professional responsibilities; and,

    3. veracity in scholarly pursuits.

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17.30 CLER Site Visit

The CLER site visit team shall include at least one professional CLER Field Representative employed by the ACGME and may include volunteer site visitors from other ACGME-accredited institutions. The size and composition of the CLER site visit team will be determined by the size and complexity of the Sponsoring Institution to be visited.

The ACGME does not require a Sponsoring Institution to submit information to the ACGME prior to a CLER site visit.

Each Sponsoring Institution must undergo a CLER site visit, as requested by the ACGME. The ACGME shall notify the Sponsoring Institution's designated institutional official of the CLER site visit team's arrival date and expected length of visit no less than 10 days prior to the visit.

The CLER site visit team shall conduct interviews with faculty members, program directors, residents and fellows, participating site personnel, institutional leadership, and other selected staff members.

The CLER site visit team shall provide a verbal summary of its findings at the end of the visit.

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17.40 CLER Reports

The CLER site visit team shall synthesize the information gleaned from the visit into a report (Policy 17.50), which will identify strengths and areas for improvement in each of the six CLER Focus Areas. The CLER site visit team shall first share its findings orally during the exit interview with the designated institutional official of the Sponsoring Institution and the senior leadership of the participating site that was visited. Subsequently, the Sponsoring Institution shall receive a copy of the written report and have the opportunity to provide a written response. The report and accompanying response shall then be forwarded as needed to the CLER Evaluation Committee for review.

The information derived from these visits is a component of the ACGME's continuous data acquisition of ACGME-accredited Sponsoring Institutions and programs. CLER Program findings shall not result in an adverse accreditation action. If the CLER site visit team identifies potential egregious violations of accreditation requirements, the ACGME will follow its policy and process for investigating egregious violations (Policy 24.00).

Annually, a summary of the national experience shall be published by the ACGME. No individual institution will be identified without first receiving permission from the institution.

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17.50 CLER Evaluation Committee

17.51 Purpose

The CLER Evaluation Committee shall annually review data from CLER site visit teams and make recommendations to the Sponsoring Institutions and their participating sites as related to the six CLER Focus Areas.

17.52 Composition

The CLER Evaluation Committee shall be comprised of physician and non-physician members, at least two of whom must be residents or fellows at the time of appointment.

The CLER Evaluation Committee shall include individuals with expertise in the following areas: patient safety; quality improvement; graduate medical education; and hospital administration, consistent with Policy 3.00. The CLER Evaluation Committee shall also include representatives of the public and may include members from federal agencies.

The ACGME Chief Sponsoring Institutions and Clinical Learning Environment Officer shall serve as a member and Co-Chair of the CLER Evaluation Committee. The other Co-Chair shall be elected by the members of the CLER Evaluation Committee.

17.53 Appointment

Candidates for membership on the CLER Evaluation Committee shall be solicited from the Member Organizations of the ACGME; the ACGME Board; the Council of Review Committee Chairs; the Council of Review Committee Residents; the graduate medical education, safety, and quality communities at-large; and the public. The Chief Sponsoring Institutions and Clinical Learning Environment Officer will select candidates and communicate recommendations to the ACGME Executive Committee for appointment and confirmation by the ACGME Board.

17.54 Terms

CLER Evaluation Committee members appointed by the ACGME Board shall be appointed to three-year terms with the option to renew for one additional three-year term. The resident/fellow members shall be appointed to single, two-year, non-renewable terms.

The volunteer Co-Chair shall be elected for a three-year term from the membership of the CLER Evaluation Committee and shall not be eligible for re-election as volunteer Co-Chair. If a CLER Evaluation Committee member is elected Co-Chair with only two years remaining in that member's six-year term, the term may be extended by one year to allow the member to fulfill the three-year term as Co-Chair.

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17.60 Failure to Undergo a CLER Site Visit

If a Sponsoring Institution fails to undergo a CLER site visit, the administration of the ACGME may recommend to the ACGME Board that it place that Sponsoring Institution on Administrative Probationary Accreditation (Policy 19.80) for no less than 18 months and no more than 24 months. A status of Administrative Probationary Accreditation may not be appealed.

If a status of Administrative Probation is conferred, the Sponsoring Institution may not:

a. apply for accreditation of new programs; or,

b. request a permanent increase in resident/fellow complement for any accredited program. The status of Administrative Probationary Accreditation shall be publicly listed on the ACGME website.

If a Sponsoring Institution fails to undergo a CLER site visit while on Administrative Probationary Accreditation, the administration of the ACGME may recommend to the ACGME Board that the accreditation of the Sponsoring Institution be administratively withdrawn pursuant to Policies 19.300.a.6., 19.300.b., and 19.300.c.

The status of Administrative Probationary Accreditation shall be removed upon successful completion of a CLER site visit but no earlier than 18 months after Administrative Probationary Accreditation was conferred.

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18.00 The Accreditation Process

18.10 Accreditation Applications

a. Sponsoring Institutions

The application process for accreditation of Sponsoring Institutions is initiated by the designated institutional official (DIO)'s submission of the "Intent to Apply for Institutional Accreditation" form, available on the ACGME website. The DIO is then given access to the ACGME's Accreditation Data System (ADS) to complete and submit the application for institutional accreditation to the ACGME. The Institutional Review Committee shall review the submitted application to determine if the institution is in substantial compliance with the Institutional Requirements.

b. Specialty, Subspecialty, and Sub-Subspecialty Programs

Applications for accreditation of a specialty, subspecialty, or sub-subspecialty program are initiated in ADS by the DIO of the program's ACGME-accredited Sponsoring Institution. The DIO is responsible for identifying basic information about the program, including the identification of the program director, in ADS. The program director is then responsible for preparation of the application for submission. The DIO is responsible for submission of the completed program application to the ACGME in ADS.

c. Dependent Subspecialty Programs and Combined Programs

An application for accreditation of a dependent subspecialty program or a combined program will be reviewed only if the accreditation status of its associated specialty or subspecialty program(s) is Continued Accreditation, Continued Accreditation with Warning, or Continued Accreditation without Outcomes, except that, at the discretion of a Review Committee, an application of a dependent subspecialty program or combined program may be reviewed when the associated specialty or subspecialty program holds a status of Initial Accreditation.

18.11 Application of a Previously Accredited Sponsoring Institution or Program

If a Sponsoring Institution or program applies for accreditation within two years of the effective date of a previous Withdrawal of Accreditation, the history of the previous accreditation action shall be included and considered by the Review Committee as a component of the application. The Sponsoring Institution or program shall include a statement addressing each previous citation in the application. The Review Committee shall consider whether the application demonstrates substantial compliance with previous areas of non-compliance in conferring an accreditation decision.

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18.12 Accreditation Site Visits for Applications

a. An accreditation site visit is required for new residency program applications; other applications may require an accreditation site visit at the discretion of the Review Committee or as otherwise provided in these policies.

b. An accreditation site visit shall be conducted for all program applications after Withdrawal of Accreditation of the same program.

c. Information used by a Review Committee to confer an accreditation decision includes, but is not limited to:

   1. the submitted application;

   2. an accreditation Site Visit Report, if applicable;

   3. the history of the Sponsoring Institution and/or the program, as applicable;

   4. public information deemed reliable;

   5. correspondence pertinent to the review; and,

   6. additional information, as required by the Review Committee,

18.13 Accreditation Status Options for Applications

The accreditation status decision of Review Committee on applications shall be based on the demonstration of substantial compliance with the applicable accreditation requirements. The following actions are available for applications of Sponsoring Institutions and programs:

a. Accreditation Withheld (Policy 19.10)

b. Initial Accreditation (Policies 19.20-19.21)

18.14 Accreditation Effective Date

A Review Committee may confer an effective date of Initial Accreditation, that is the date of the decision, the beginning of the next academic year or retroactive to the beginning of the academic year during which the decision is made.

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18.20 The Accreditation Site Visit

The accreditation process for Sponsoring Institutions and programs includes site visits to address compliance with the Institutional and Program Requirements, as applicable. All accreditation site visits for Sponsoring Institutions and programs are performed by Accreditation Field Representatives who are employed by the ACGME.

Accreditation site visits are conducted by individual Accreditation Field Representatives, or by a team made up of Accreditation Field Representatives. In certain circumstances, the site visit team may include peer representatives.

18.21 The Accreditation Site Visit Scheduling Process

Sponsoring Institutions and programs with an approximate accreditation site visit date in the Accreditation Data System (ADS) may be scheduled for a site visit. ACGME Field Activities staff members shall initiate the scheduling process in collaboration with the Sponsoring Institution or program to determine a date for the visit. Once a date for the visit is determined, a Site Visit Announcement letter shall be sent confirming the date(s) of the visit, assigned Accreditation Field Representative(s), and other information to prepare for the visit. Site visits may be “announced” or “unannounced.”

18.22 Preparation for an Accreditation Site Visit

The Site Visit Announcement letter contains instructions to update ADS in preparation for the site visit, as well as other information about the day of the visit. The Accreditation Field Representative(s) shall communicate directly with the Sponsoring Institution or program about the site visit interview schedule. Accreditation Field Representatives are provided with information from ADS regarding the Sponsoring Institution and program to be visited, as well as other information in preparation for the site visit.

18.23 Day of the Accreditation Site Visit

During an accreditation site visit of a Sponsoring Institution or program, Accreditation Field Representatives shall conduct interviews. Interviewees for an accreditation site visit shall include but not be limited to designated institutional officials, program directors, coordinators, faculty members, administrative staff members, residents, and fellows. Interviews can take place in person and/or remotely using audio/audio-visual technology.

18.24 After the Accreditation Site Visit

Accreditation Field Representative(s) shall prepare a Site Visit Report after each site visit, which shall be submitted to the Review Committee or to the President and Chief Executive Officer of the ACGME.

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18.30 The Sponsoring Institution 10-Year Accreditation Site Visit

Sponsoring Institutions will undergo a 10-Year Accreditation Site Visit independent of the annual review process.

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19.00 Accreditation and Administrative Actions

a. The following accreditation and administrative status options may be conferred on Sponsoring Institutions and programs:

- Accreditation Withheld (Policies 19.10-19.12)
- Initial Accreditation (Policies 19.20-19.21)
- Initial Accreditation with Warning (Policies 19.30-19.31)
- Continued Accreditation without Outcomes (Policies 19.40-19.41)
- Continued Accreditation (Policies 19.50-19.51)
- Continued Accreditation with Warning (Policies 19.60-19.61)
- Probationary Accreditation (Policies 19.70-19.71)
- Administrative Probationary Accreditation (Policy 19.80)
- Withdrawal of Accreditation (Policies 19.90-19.91)
- Expedited Withdrawal of Accreditation (Policies 19.90-19.91)
- Voluntary Withdrawal of Accreditation (Policies 19.200-19.202)
- Administrative Withdrawal of Accreditation (Policies 19.300-19.301)
- Administrative Withdrawal due to withdrawal of sponsoring program's accreditation

b. The following adverse accreditation statuses may be appealed:

- Accreditation Withheld (Policies 19.10-19.12)
- Probationary Accreditation (Policies 19.70-19.71)
- Withdrawal of Accreditation (Policies 19.90-19.91)
- Expedited Withdrawal of Accreditation (Policies 19.90-19.91)
- Reduction in Resident Complement (Policy 19.500)

c. Sponsoring Institutions and programs may not appeal other accreditation status decisions or actions (e.g., citations, warnings).

d. Following review of a Sponsoring Institution, a Letter of Notification including the action(s) of the Review Committee shall be sent to the designated institutional official (DIO). Following review of a program, the program director will likewise receive a Letter of Notification, with a copy sent to the DIO.

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19.10 Accreditation Withheld

Accreditation shall be withheld when a Review Committee determines that an application for a new Sponsoring Institution or program has not demonstrated substantial compliance with the applicable requirements. Accreditation Withheld is an adverse accreditation decision and is subject to appeal.

A Review Committee shall confer a status effective date that is the date of the decision.

19.11 Reapplication

A Sponsoring Institution or program may reapply after having its application withheld. If a Sponsoring Institution or program reapplies for accreditation within two years of the effective date of a status of Accreditation Withheld, the accreditation history of the previous accreditation action shall be included as part of the file. A program may reapply for accreditation only to the same Review Committee. The Sponsoring Institution or program shall include a statement addressing each previous citation with the new application.

19.12 Site Visit Prior to Next Review by the Review Committee

An accreditation site visit shall be conducted for all Sponsoring Institution and program re-applications submitted within two years of the effective date of a decision of Accreditation Withheld. However, an accreditation site visit may be conducted for reapplications of subspecialty programs.

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19.20 Initial Accreditation

Initial Accreditation is a developmental period of accreditation, following demonstration of substantial compliance with the applicable Requirements after submission of an application. Programs with a status of Initial Accreditation may not request a permanent increase in resident or fellow complement or an exception to requirements addressing clinical work and education hours. Programs must continue to demonstrate substantial compliance with all program requirements (core, detail, outcome).

A status of Initial Accreditation may be conferred when separately accredited Sponsoring Institutions or programs merge, or when an accredited Sponsoring Institution or program has been so altered that in the judgment of the Review Committee it is the equivalent of a new Sponsoring Institution or program.

A Review Committee may confer an effective date of Initial Accreditation, that is the date of the decision, the beginning of the next academic year or retroactive to the beginning of the academic year during which the decision is made.

19.21 Review of a Sponsoring Institution or Program with a Status of Initial Accreditation

a. Timing of the Accreditation Site Visit

   An accreditation site visit shall be conducted approximately two years from the effective date of Initial Accreditation. If a program does not matriculate residents or fellows in the first two years, an accreditation site visit shall be conducted approximately three years from the effective date.

b. Information used by the Review Committee to confer a status decision may include but is not limited to:

   1. an updated accreditation application;
   2. Site Visit Report;
   3. history of the Sponsoring Institution and/or program, as applicable;
   4. correspondence pertinent to the review;
   5. public information deemed reliable; and,
   6. additional information, as requested by the committee.

c. Based on consideration of the information described in (b), the following options are available *prior* to conferring an accreditation status include:

   1. request an accreditation site visit; or,
   2. request additional information.

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19.00 Accreditation and Administrative Actions

19.20 Initial Accreditation

19.21 Review of a Sponsoring Institution or Program with a Status of Initial Accreditation

d. Available accreditation status options include:

1. Initial Accreditation with Warning for one year (Policies 19.30-19.31)

2. Continued Accreditation without Outcomes (Policies 19.40-19.41)

3. Continued Accreditation (Policies 19.50-19.51)

4. Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

5. Expedited Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

e. Available action options *when* conferring an accreditation status include:

1. issue, extend, or resolve a citation(s);

2. issue an Area for Improvement(s) *(not applicable to status of Accreditation Withheld);*

3. request a progress report *(not applicable to status of Accreditation Withheld);*

4. commend exemplary performance or innovations in graduate medical education;

5. issue a decision regarding a change in resident/fellow complement *(programs only)*;

6. reduce resident/fellow complement (programs only); or,

7. other actions, as appropriate to the circumstances.

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19.30 Initial Accreditation with Warning

Following the developmental period of Initial Accreditation, if a Sponsoring Institution or program fails to demonstrate substantial compliance with the applicable Requirements, a Review Committee may confer a status of Initial Accreditation with Warning for a duration of one year.

If, after an accreditation site visit, the Sponsoring Institution or program again fails to demonstrate substantial compliance, the Review Committee may confer a second year of Initial Accreditation with Warning or confer Withdrawal of Accreditation.

If, after a second decision of Initial Accreditation with Warning, and after a subsequent accreditation site visit, the Sponsoring Institution or program fails to achieve substantial compliance with the applicable Requirements, the Review Committee shall confer the status of Withdrawal of Accreditation.

Programs with a status of Initial Accreditation with Warning may not request a permanent increase in resident or fellow complement or an exception to the requirement addressing the 80-hour weekly limit on clinical work and education hours.

Sponsoring Institutions and programs with a status of Initial Accreditation with Warning must continue to demonstrate substantial compliance with all applicable requirements (Core, Detail, Outcome).

A Review Committee shall confer an accreditation status effective date that is the date of the decision.

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19.00 Accreditation and Administrative Actions

19.30 Initial Accreditation with Warning

19.31 Review of a Sponsoring Institution or Program with a Status of Initial Accreditation with Warning

a. Timing of Review by the Review Committee and Site Visit

A Sponsoring Institution or program shall be scheduled for review approximately one year after a status of Initial Accreditation with Warning is conferred. An accreditation site visit of the Sponsoring Institution or program must occur prior to this review. If a Sponsoring Institution or program is conferred with the status of Initial Accreditation with Warning for a second year, the Sponsoring Institution or program shall be required to have an accreditation site visit prior to the end of the second year.

b. Information used by the Review Committee to confer a status decision may include but is not limited to:

1. an updated accreditation application;
2. Site Visit Report;
3. history of the Sponsoring Institution and/or program, as applicable;
4. correspondence pertinent to the review;
5. public information deemed reliable; and,
6. additional information, as requested by the committee.

c. Based on consideration of the information described in (b), the following options are available *prior* to conferring an accreditation status:

1. request an accreditation site visit; or,
2. request additional information.

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19.00 Accreditation and Administrative Actions

19.30 Initial Accreditation with Warning

19.31 Review of a Sponsoring Institution or Program with a Status of Initial Accreditation with Warning

d. Available accreditation status options:

1. Initial Accreditation with Warning *(not an option for Sponsoring Institutions or programs that have had a status of Initial Accreditation with Warning conferred twice)* (Policies 19.30-19.31)

2. Continued Accreditation without Outcomes (Policies 19.40-19.41)

3. Continued Accreditation (Policies 19.50-19.51)

4. Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

5. Expedited Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

e. Available action options *when* conferring an accreditation status include:

1. issue, extend, or resolve a citation(s);

2. issue an Area for Improvement(s) *(not applicable to status of Withdrawal of Accreditation)*;

3. request a progress report *(not applicable to status of Withdrawal of Accreditation)*;

4. commend exemplary performance or innovations in graduate medical education;

5. issue a decision regarding a change in resident/fellow complement *(programs only)*;

6. reduce resident/fellow complement *(programs only)*; or,

7. other actions, as appropriate to the circumstances.

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19.40 Continued Accreditation without Outcomes

The accreditation status of Continued Accreditation without Outcomes may be conferred on a new program with Initial Accreditation or Initial Accreditation with Warning that, upon review, has demonstrated substantial compliance with the applicable requirements that have been assessed based on the available data but has insufficient data to be conferred the status of Continued Accreditation. Examples include, the program:

a. has not had a resident/fellow complete the program since accreditation was initially conferred, and therefore cannot report on Case Logs, if applicable;

b. has not had a resident/fellow complete the program since accreditation was initially conferred, and therefore cannot report on graduate patient numerics, if applicable (e.g., family medicine); and/or,

c. has not had a resident/fellow who has taken a certifying examination in the specialty or subspecialty, and therefore cannot report on board pass rate.

Programs with a status of Continued Accreditation without Outcomes are subject to accreditation citation under “Detail,” “Core,” and “Outcome,” categorized requirements except for the requirements addressing a., b., and c. above. Although programs with a status of Continued Accreditation without Outcomes are not subject to accreditation citation under requirements addressing a., b., and c. above, they are expected to comply with those requirements, as well as all other Core- and Outcome-categorized requirements, upon progression to the status of “Continued Accreditation.”

The Review Committee shall confer an effective date that is the date of the decision.

19.41 Review of a Program with a Status of Continued Accreditation without Outcomes

a. Timing of the Review by the Review Committee and an Accreditation Site Visit

   Programs shall be reviewed annually. In rare circumstances, the Review Committee may defer the review of a program in a given academic year. A program accreditation site visit may be scheduled at the discretion of the Review Committee.

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19.00 Accreditation and Administrative Actions

19.40 Continued Accreditation without Outcomes

19.41 Review of a Program with a Status of Continued Accreditation without Outcomes

b. Information used by the Review Committee to confer a status may include but is not limited to:

1. review of annual data;

2. Site Visit Report;

3. history of the Sponsoring Institution and/or program, as applicable;

4. correspondence pertinent to the review;

5. public information deemed reliable; and,

6. additional information, as requested by the Committee.

c. Based on consideration of the information described in (b) above, the following options are available *prior* to conferring an accreditation status:

1. request an accreditation site visit; or,

2. request additional information.

d. Available accreditation status options:

Programs holding a status of Continued Accreditation without Outcomes must not remain in the status longer than the length of the educational program plus one year, at which time the Review Committee must confer one of the following statuses.

1. Continued Accreditation (Policies 19.50-19.51)

2. Continued Accreditation with Warning (Policies 19.60-19.61)

3. Probationary Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.70-19.71)

4. Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

5. Expedited Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

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19.00 Accreditation and Administrative Actions

19.40 Continued Accreditation without Outcomes

19.41 Review of a Program with a Status of Continued Accreditation without Outcomes

e. Available action options *when* conferring an accreditation status are:

1. issue, extend, or resolve a citation(s);
2. issue an Area for Improvement(s) *(not applicable for programs with a status of Probationary Accreditation or Withdrawal of Accreditation)*;
3. request a progress report *(not applicable for programs with a status of Probationary Accreditation or Withdrawal of Accreditation)*;
4. commend exemplary performance or innovations in graduate medical education;
5. issue a decision regarding a change in complement *(programs only)*;
6. reduce resident/fellow complement *(programs only)*; or,
7. other actions, as appropriate to the circumstances.

19.50 Continued Accreditation

A Review Committee may confer a status of Continued Accreditation on a Sponsoring Institution or program holding a status of Initial Accreditation, Initial Accreditation with Warning, Continued Accreditation without Outcomes (status is not applicable to a Sponsoring Institution), Continued Accreditation with Warning, or Probationary Accreditation that upon review has demonstrated substantial compliance with the applicable Requirements.

Sponsoring Institutions and programs holding a status of Continued Accreditation are subject to accreditation review of Core and Outcome categorized requirements.

A Review Committee shall confer an effective date that is the date of the decision.

19.51 Review of a Sponsoring Institution or Program with a Status of Continued Accreditation

a. Timing of Review by the Review Committee and an Accreditation Site Visit

   Sponsoring Institutions and programs shall be reviewed annually. In rare circumstances, the Review Committee may defer the review of a Sponsoring Institution or program in a given academic year.

   Sponsoring Institution and program accreditation site visits may be scheduled at the discretion of the Review Committee.

   In addition to the annual review, a Sponsoring Institution 10 Year Accreditation Site Visit and review will be conducted approximately every 10 years.

b. Information used by the Review Committee to confer a status may include, but is not limited to:

   1. review of annual data;
   2. Site Visit Report (if applicable);
   3. history of the Sponsoring Institution and/or program, as applicable;
   4. correspondence pertinent to the review;
   5. public information deemed reliable; and,
   6. additional information, as requested by the Committee.

c. Based on consideration of the information described in (b) above, the following options are available *prior* to conferring an accreditation status include:

   1. request an accreditation site visit; or,
   2. request additional information.

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19.00 Accreditation and Administrative Actions

19.51 Review of a Sponsoring Institution or Program with a Status of Continued Accreditation

d. Available accreditation status options are:

1. Continued Accreditation (Policies 19.50-19.51)

2. Continued Accreditation with Warning (Policies 19.60-19.61)

3. Probationary Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.70-19.71)

4. Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

5. Expedited Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

e. Available action options *when* conferring an accreditation status are:

1. issue, extend, or resolve a citation(s);

2. issue an Area for Improvement(s) *(not applicable for Sponsoring Institutions or programs with a status of Probationary Accreditation or Withdrawal of Accreditation)*;

3. request a progress report *(not applicable for Sponsoring Institutions or programs with a status of Probationary Accreditation or Withdrawal of Accreditation)*;

4. commend exemplary performance or innovations in graduate medical education;

5. issue a decision regarding a change in complement *(programs only)*;

6. reduce resident/fellow complement *(programs only)*; or,

7. other actions, as appropriate to the circumstances.

19.60 Continued Accreditation with Warning

A Review Committee may confer a status of Continued Accreditation with Warning if it has determined that a Sponsoring Institution or program has areas of non-compliance with the applicable Requirements that may jeopardize its accreditation status.

Sponsoring Institutions and programs holding a status of Continued Accreditation with Warning are subject to accreditation review of Detail, Core, and Outcome categorized requirements.

Programs with the status of Continued Accreditation with Warning may not request a permanent increase in resident/fellow complement or an exception to requirement addressing the 80-hour weekly limit on clinical work and education hours.

A Review Committee shall confer an effective date that is the date of the decision.

19.61 Review of a Sponsoring Institution or Program with a Status of Continued Accreditation with Warning

a. Timing of Review by the Review Committee and an Accreditation Site Visit

   Sponsoring Institutions and programs shall be reviewed annually. In rare circumstances, the Review Committee may defer the review of a Sponsoring Institution or program in a given academic year.

   Sponsoring Institution and program accreditation site visits may be scheduled at the discretion of the Review Committee.

   In addition to the annual review, a Sponsoring Institution 10 Year Accreditation Site Visit and review will be conducted approximately every 10 years.

b. Information used by the Review Committee to confer a status decision may include but is not limited to:

   1. review of annual data;
   2. Site Visit Report (if applicable);
   3. history of the Sponsoring Institution and/or program, as applicable;
   4. correspondence pertinent to the review;
   5. public information deemed reliable; and,
   6. additional information, as requested by the Committee.

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19.00 Accreditation and Administrative Actions

19.60 Continued Accreditation with Warning

19.61 Review of a Sponsoring Institution or Program with a Status of Continued Accreditation with Warning

c. Based on consideration of the information described in (b) above, the following options are available *prior* to conferring an accreditation status include:

1. request an accreditation site visit; or,

2. request additional information.

d. Available accreditation status options are:

1. Continued Accreditation (Policies 19.50-19.51)

2. Continued Accreditation with Warning (Policies 19.60-19.61)

3. Probationary Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.70-19.71)

4. Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

5. Expedited Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

e. Available action options *when* conferring an accreditation status are:

1. issue, extend, or resolve a citation(s);

2. issue an Area for Improvement(s) *(not applicable for Sponsoring Institutions or programs with a status of Probationary Accreditation or Withdrawal of Accreditation)*;

3. request a progress report *(not applicable for Sponsoring Institutions or programs with a status of Probationary Accreditation or Withdrawal of Accreditation)*;

4. commend exemplary performance or innovations in graduate medical education;

5. issue a decision regarding a change in complement *(programs only)*;

6. reduce resident/fellow complement *(programs only)*; or,

7. other actions, as appropriate to the circumstances.

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19.70 Probationary Accreditation

A Review Committee may confer a status of Probationary Accreditation if it has determined that a Sponsoring Institution or program has failed to demonstrate substantial compliance with the applicable Requirements confirmed by the findings of an accreditation site visit. Probationary Accreditation is an adverse accreditation decision and is subject to appeal (Policy 19.00.b.).

Sponsoring Institutions and programs holding a status of Probationary Accreditation are subject to accreditation review under Detail, Core, and Outcome requirements.

Sponsoring Institutions with a status of Probationary Accreditation may not apply for or be granted accreditation of new programs.

Probationary status of a Sponsoring Institution or program shall not exceed two consecutive annual reviews, at which point the Sponsoring Institution or program must achieve a status of either Continued Accreditation or Continued Accreditation with Warning, or its accreditation will be withdrawn.

Programs with a status of Probationary Accreditation may not request a permanent increase in resident/fellow complement or an exception to the requirement addressing the 80-hour weekly limit on clinical work and education hours.

All applicants invited to interview, and residents/fellows accepted into or enrolled in a program with or sponsored by a Sponsoring Institution with Probationary Accreditation must be notified in writing of the probationary status.

A Review Committee shall confer an effective date, that is the date of the decision.

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19.00 Accreditation and Administrative Actions

19.70 Probationary Accreditation

19.71 Review of a Sponsoring Institution or Program with a Status of Probationary Accreditation

a. Timing of Review by the Review Committee and Site Visit
Sponsoring Institutions and programs shall be reviewed annually. A site visit shall be conducted annually for a Sponsoring Institution or program with a status of Probationary Accreditation. In rare circumstances, the Review Committee may defer the review of a Sponsoring Institution or program in a given academic year.

b. Information used by the Review Committee to confer a status decision may include but is not limited to:

   1. review of annual data;

   2. Site Visit Report;

   3. history of the Sponsoring Institution and/or program, as applicable;

   4. correspondence pertinent to the review;

   5. public information deemed reliable; and,

   6. additional information, as requested by the Committee.

c. Based on consideration of the information described in (b), the following options are available *prior* to conferring an accreditation status include:

   1. request an accreditation site visit; or,

   2. request additional information.

d. Available accreditation status options:

   1. Continued Accreditation (Policies 19.50-19.51)

   2. Continued Accreditation with Warning (Policies 19.60-19.61)

   3. Probationary Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.70-19.71)

   4. Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

   5. Expedited Withdrawal of Accreditation *(accreditation site visit required before conferring this status)* (Policies 19.90-19.91)

19.00 Accreditation and Administrative Actions

19.70 Probationary Accreditation

19.71 Review of a Sponsoring Institution or Program with a Status of Probationary Accreditation

e. Available action options *when* conferring an accreditation status include:

1. issue, extend, or resolve a citation(s) (if applicable);
2. issue a decision regarding a change in complement *(programs only)*;
3. reduce resident/fellow complement *(programs only)*; or,
4. other actions, as appropriate to the circumstances.

19.80 Administrative Probationary Accreditation

If a Sponsoring Institution fails to undergo a CLER site visit, the administration of the ACGME may recommend to the ACGME Board that it place that Sponsoring Institution on Administrative Probationary Accreditation for no less than 18 months and no more than 24 months (Policy 17.60).

A status of Administrative Probationary Accreditation may not be appealed.

19.90 Withdrawal of Accreditation and Expedited Withdrawal of Accreditation

a. Withdrawal of Accreditation

A Review Committee may confer a status of Withdrawal of Accreditation if it has determined that a Sponsoring Institution or program has failed to demonstrate substantial compliance with the applicable Requirements. Withdrawal of Accreditation is an adverse accreditation decision and is subject to appeal (Policy 19.00.b.).

b. Expedited Withdrawal of Accreditation

A Review Committee may confer a status of Expedited Withdrawal of Accreditation if it determines that a Sponsoring Institution or program has failed to demonstrate substantial compliance with the applicable Requirements to a degree sufficient to warrant withdrawal of the Sponsoring Institution or program prior to the end of the current academic year. This action may be taken if the Review Committee determines that resident/fellow education and/or patient care are compromised to a degree warranting such withdrawal; the education and training environment does not support an adequate educational experience for the residents/fellows; the safety of residents/fellows, faculty members, and/or other health care personnel are in jeopardy; and/or there are other circumstances warranting such withdrawal.

19.91 Effective Date of Withdrawal of Accreditation and Expedited Withdrawal of Accreditation

a. Withdrawal of Accreditation

The effective date of Withdrawal of Accreditation shall be determined by the Review Committee. The effective date shall be June 30 of the current academic year, June 30 of the following academic year, or, in the discretion of the Review Committee to allow for academic year completion of any off-cycle residents, a date within the following academic year.

b. Expedited Withdrawal of Accreditation

The effective date of Expedited Withdrawal of Accreditation shall be determined by the Review Committee. The effective date should be at least 30 days, and no more than 90 days, from the date the Letter of Notification is provided to the Sponsoring Institution or program and should not extend into the next academic year.

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19.100 Responsibilities of the Sponsoring Institution or Program upon Withdrawal of Accreditation and Expedited Withdrawal of Accreditation

a. Upon Withdrawal or Expedited Withdrawal of Accreditation of a program, the accreditation of all its dependent subspecialty, sub-subspecialty, and combined programs shall be administratively withdrawn.

b. Upon the program's receipt of the notification of Withdrawal of Accreditation or Expedited Withdrawal of Accreditation, all applicants invited to interview and residents/fellows accepted into or enrolled in the program must be notified in writing of the withdrawal and its effective date. This notification must include confirmation that the residents/fellows will be permitted to leave the program following the effective date of Withdrawal or Expedited Withdrawal of Accreditation, regardless of whether the program appeals the decision.

c. No new residents/fellows may be appointed to a program after the effective date of Withdrawal of Accreditation, Expedited Withdrawal of Accreditation, or Administrative Withdrawal of Accreditation.

d. Upon Withdrawal or Expedited Withdrawal of a Sponsoring Institution's accreditation, the accreditation of all its programs shall be administratively withdrawn. The Institutional Review Committee shall coordinate communications and activities with all affected Review Committees.

e. Upon the Sponsoring Institution's receipt of notification of the Withdrawal of Accreditation, Expedited Withdrawal of Accreditation, or Administrative Withdrawal of Accreditation, all applicants invited to interview and residents/fellows accepted into or enrolled in its program(s) must be notified in writing of the withdrawal and its effective date. This notification must include confirmation that the residents/fellows will be permitted to leave the program(s) following the effective date of Withdrawal of Accreditation, Expedited Withdrawal of Accreditation, or Administrative Withdrawal of Accreditation regardless of whether the Sponsoring Institution appeals the decision.

f. For Withdrawal of Accreditation of a Sponsoring Institution or program, a copy of the written notice to applicants and residents/fellows must be uploaded into the ACGME's Accreditation Data System (ADS) within 30 days of receipt of the Review Committee's Letter of Notification.

g. For Expedited Withdrawal of Accreditation of a Sponsoring Institution or program, a copy of the written notice to applicants and residents/fellows must be uploaded into (ADS) within three business days of receipt of the Review Committee's Letter of Notification.

h. The Sponsoring Institution and the program must ensure placement, and transfer records of residents/fellows currently accepted into or enrolled in all withdrawn programs into other ACGME-accredited programs in their current specialty, unless the resident/fellow requests otherwise, to minimizes loss of education and training time. The Sponsoring Institution is responsible for ensuring that the program(s) update the resident/fellow rosters in ADS in real time.

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19.101 Re-application after Withdrawal of Accreditation or Expedited Withdrawal of Accreditation

A Sponsoring Institution or program may reapply for accreditation before or after the effective date of withdrawal of Accreditation or Expedited Withdrawal of Accreditation.

If a Sponsoring Institution or program reapplies for accreditation before, or within 24 months after, the effective date of Withdrawal of Accreditation or Expedited Withdrawal of Accreditation, its accreditation history and its reapplication shall be considered by the Review Committee. A program may reapply for accreditation only to the same Review Committee. In its reapplication, the Sponsoring Institution or program must include a response to each previous citation that forms the basis of the withdrawal.

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19.200 Voluntary Withdrawal of Accreditation

Upon voluntary withdrawal of a Sponsoring Institution's accreditation, the accreditation of all its sponsored programs will be administratively withdrawn. The Institutional Review Committee shall coordinate communications and activities with all affected Review Committees.

19.201 Requests for Voluntary Withdrawal of Accreditation

a. Requests for Voluntary Withdrawal of Accreditation of a Sponsoring Institution must:

   1. be submitted through the Accreditation Data System (ADS) by the designated institutional official (DIO) with approval by the Graduate Medical Education Committee (GMEC); and,

   2. include the effective date of withdrawal and a detailed plan for placement of all programs' current or accepted residents/fellows into other ACGME-accredited programs.

b. Requests for Voluntary Withdrawal of Accreditation of a program must:

   1. be submitted through ADS by the program director with approval by the DIO and the GMEC;

   2. include an effective date that should coincide with the end of the current academic year, except that a program operating under the Extraordinary Circumstances policy may request an earlier effective date; and,

   3. state whether residents/fellows are currently accepted into or enrolled in the program, and if so, describe a plan for placement of those residents/fellows into other ACGME-accredited programs.

c. A Sponsoring Institution or program that has requested Voluntary Withdrawal of Accreditation:

   1. may not accept new residents/fellows;

   2. may not request reversal of the action after submitting the request (regardless of the proposed effective date);

d. If a Review Committee has conferred a status of Withdrawal of Accreditation or Expedited Withdrawal of Accreditation, the Sponsoring Institution or program may not request Voluntary Withdrawal of Accreditation. The accreditation status of the Sponsoring Institution or program conferred by the Review Committee may be altered only through an appeal.

e. If, after accreditation has been voluntarily withdrawn, a Sponsoring Institution or program reapplies for accreditation within 24 months of the effective date of the voluntary withdrawal, the accreditation history of the Sponsoring Institution or program and the reapplication shall be considered by the Review Committee. In its reapplication, the Sponsoring Institution or program must include a response to each citation outstanding on the date of voluntary withdrawal.

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f. If a program reapplies for accreditation within 24 months of the effective date of Voluntary Withdrawal of Accreditation, an accreditation site visit shall be conducted.

g. The Sponsoring Institution and program(s) must arrange for placement of residents/fellows currently accepted into or enrolled in all withdrawn programs into other ACGME-accredited programs in their current specialty, unless the resident/fellow requests otherwise, to minimize interruption of education and training time. The Sponsoring Institution is responsible for ensuring that the program(s) update the resident/fellow rosters in ADS in real time.

19.300 Administrative Withdrawal of Accreditation

a. A Review Committee and/or the administration of the ACGME may recommend to the ACGME Board to confer Administrative Withdrawal of Accreditation if a Sponsoring Institution or program does not comply with the following actions and/or procedures:

   1. timely payment of fees to the ACGME;

   2. undergo an accreditation site visit;

   3. follow directives associated with an accreditation action;

   4. supply the Review Committee or ACGME staff members with requested information;

   5. maintain current data in the Accreditation Data System (ADS);

   6. undergo a Clinical Learning Environment Review (CLER) site visit and review while on Administrative Probationary Accreditation (Policy 19.80) *(Sponsoring Institutions only)*; or,

   7. matriculate residents/fellows for six or more consecutive years *(programs only)*.

b. Upon the recommendation in a. above, the ACGME Board may administratively withdraw accreditation of the Sponsoring Institution or program.

c. A status of Administrative Withdrawal of Accreditation may not be appealed.

19.301 Reapplication after Administrative Withdrawal of Accreditation

a. If a Sponsoring Institution or program reapplies for accreditation within two years after the effective date of Administrative Withdrawal of Accreditation, the accreditation history of the Sponsoring Institution or program shall be considered. The Sponsoring Institution or program shall include with the new application a statement addressing each existing citation and issue(s) leading to the Administrative Withdrawal of Accreditation.

b. An accreditation site visit may be conducted for re-applications for accreditation after Administrative Withdrawal of Accreditation.

19.400 Accreditation Actions for Dependent Subspecialty and Sub-Subspecialty and Combined Programs

Dependent programs and combined programs have the full range of accreditation status options as their associated specialty or subspecialty program(s).

a. Initial Accreditation for Dependent Subspecialty and Sub-Subspecialty Programs and Combined Programs.

   1. A request for Initial Accreditation of a dependent subspecialty/sub-subspecialty program or combined program shall be considered if the accreditation status of its associated specialty or subspecialty program(s) is Continued Accreditation, Continued Accreditation with Warning, or Continued Accreditation without Outcomes, and the associated specialty or subspecialty program(s) is not involved in any phase of an appeals process.

   2. At the discretion of the applicable Review Committee, an application of a dependent subspecialty/sub-subspecialty program or combined program may be considered if the associated specialty or subspecialty program holds a status of Initial Accreditation.

b. Administrative Withdrawal for Dependent Subspecialty and Sub-Subspecialty Programs and Combined Programs.

   1. An adverse status of an associated specialty or subspecialty program shall result in the same status being administratively conferred on its dependent subspecialty/sub-sub-specialty program(s) and associated combined programs.

   2. If accreditation is withdrawn from a specialty or subspecialty program, the accreditation of each of its dependent programs shall be administratively withdrawn with the same effective date.

19.500 Reduction in Resident/Fellow Complement

A Review Committee may reduce the approved resident/fellow complement if a program cannot demonstrate the capacity to provide each resident/fellow with a sufficient educational experience.

Reduction in Resident/Fellow Complement is an adverse accreditation decision; a program may appeal this decision (Policy 19.00.b.).

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20.00 Appeals of Adverse Accreditation Actions

20.10 Adverse Accreditation Actions

The following accreditation actions are considered adverse and may be appealed under this section with the exception of an adverse action made by the ACGME Board under the Alleged Egregious Violation Event policy (Policy 24.00).

- Accreditation Withheld (Policies 19.10-19.12)
- Probationary Accreditation (Policies 19.70-19.71)
- Withdrawal of Accreditation (Policies 19.90-19.91)
- Expedited Withdrawal of Accreditation (Policies 19.90-19.91)
- Reduction in Resident/Fellow Complement (not applicable to Sponsoring Institutions) (Policy 19.500)

20.20 Procedures for an Adverse Accreditation Action

a. When a Review Committee confers an adverse action, it shall issue a Letter of Notification which shall include the citations that form the basis for the adverse action and a copy of the Site Visit Report, if applicable.

b. For an adverse action for a Sponsoring Institution, the Letter of Notification shall be sent to the designated institutional official (DIO). For an adverse action for a program, the letter of notification will be sent to the program director with a copy to the DIO. Sponsoring Institutions and programs may appeal adverse actions; otherwise, an adverse action is final.

20.30 Procedures for Appeal of Accreditation Adverse Actions

If a Review Committee confers an adverse action, the Sponsoring Institution or program may request a hearing before an Appeals Panel. If a written request for such a hearing is not received by the President and Chief Executive Officer of the ACGME within 30 days of receipt by the Sponsoring Institution or program of the Letter of Notification of the conferral, the action of the Review Committee shall be deemed final and not subject to further appeal.

a. Appointment of the Appeals Panel

If an appeals hearing is requested, an Appeals Panel shall be appointed according to the following procedures:

1. the ACGME shall maintain a list of qualified persons as potential members for appointment to Appeals Panels;

2. for a given hearing, the Sponsoring Institution or program shall receive a copy of the list of potential Appeals Panel members and shall have an opportunity to delete a maximum of one-third of the names from this list; within 15 days of receipt of this list, the Sponsoring Institution or program shall submit its revised list as directed in the letter acknowledging the appeal; and,

20.00 Appeals of Adverse Accreditation Actions

20.30 Procedures for Appeal of Accreditation Adverse Actions

3. a three-member Appeals Panel shall be constituted by the ACGME from among the remaining names on the list.

b. Upon request for a hearing, the following policies and procedures shall apply:

When a Sponsoring Institution or program requests a hearing before an Appeals Panel, the Sponsoring Institution or program holds the accreditation status determined by the Review Committee with the addition of the term “under appeal.” This accreditation status shall remain in effect until the ACGME makes a final determination on the accreditation status of the Sponsoring Institution or program in the appeal process.

1. Upon the Sponsoring Institution or program’s receipt of the notification of conferral of Accreditation Withheld, Probationary Accreditation, Withdrawal of Accreditation, or Expedited Withdrawal of Accreditation, all applicants invited to interview, and residents/fellows accepted into or enrolled in the program(s) must be notified in writing of the accreditation status and its effective date. This notification must include confirmation that the residents/fellows will be permitted to leave the program following the effective date of Withdrawal of Accreditation or Expedited Withdrawal of Accreditation regardless of whether the Sponsoring Institution or program appeals the decision.

2. Residents/fellows who remain in a program with a status of Withdrawal of Accreditation under appeal or Expedited Withdrawal of Accreditation under appeal must be advised by the Sponsoring Institution and program on the impact of the Sponsoring Institution/program status and appeal on the residents’/fellows’ eligibility for certifying board examinations.

3. Hearings conducted in conformity with these procedures shall be held at a time and place to be determined by the ACGME. At least 25 days prior to its hearing, a Sponsoring Institution or program shall be notified of the time and place of the hearing.

4. A Sponsoring Institution or program shall be given the documents comprising the Sponsoring Institution or program file and the record of the Review Committee’s action.

5. The documents comprising the Sponsoring Institution or program file and the record of the Review Committee’s action, together with oral and written presentations to the Appeals Panel, shall be the basis for the final recommendations of the Appeals Panel.

6. The Appeals Panel shall meet to review the written record and receive the presentations. The applicable Review Committee shall be notified of the hearing and a representative of the Review Committee shall attend the hearing.

7. Proceedings before an Appeals Panel are not of an adversarial nature as typical in a court of law, but rather provide an administrative mechanism for peer review of an accreditation decision for an educational Sponsoring institution or program. The Appeals Panel shall not be bound by technical rules of evidence usually employed in legal proceedings.

8. The appellant may be represented by no more than five individuals at the hearing.

20.00 Appeals of Adverse Accreditation Actions

20.30 Procedures for Appeal of Accreditation Adverse Actions

9. Presentations shall be limited to clarifications of the record focusing on information addressing:

   a) compliance with the applicable published Requirements for accreditation at the time of the Review Committee review and conferral of the adverse action; and,

   b) the review of the Sponsoring Institution or program according to the applicable procedures.

10. Presentations may include written and oral elements. Any information, including presentations and audio/visual and written materials, must be provided to the ACGME a minimum of 10 business days prior to the hearing.

    The order of presentations shall be:

    a) The appellant shall make an initial presentation to the Appeals Panel, which shall be limited to two hours.

    b) The Review Committee representative shall make a presentation to the Appeals Panel, which shall be limited to one hour.

    c) The appellant may make a presentation to the Appeals Panel in response to the Review Committee representative's presentation, which shall be limited to one hour.

    d) The Appeals Panel may ask questions of the appellant and/or the Review Committee representative for up to one hour.

    e) The appellant may make a closing statement, which shall be limited to 15 minutes.

11. The Appeals Panel shall not consider any changes in the Sponsoring Institution or program or descriptions of the Sponsoring Institution or program that were not in the record at the time the Review Committee reviewed it and conferred the adverse action.

12. The appellant shall not communicate with the Appeals Panel before or after the hearing.

13. The Appeals Panel shall make recommendations to the ACGME Board as to whether substantial, credible, and relevant evidence exists to support the action taken by the Review Committee in the matter under appeal. The Appeals Panel shall, in addition, make recommendations as to whether there has been substantial compliance with the administrative procedures that govern the process of accreditation of graduate medical education Sponsoring Institutions or programs.

14. The Appeals Panel may recommend upholding the Review Committee's decision, restoring the Sponsoring Institution or program to its previous accreditation status, or, in the case of Accreditation Withheld, conferring Initial Accreditation.

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20.00 Appeals of Adverse Accreditation Actions

20.30 Procedures for Appeal of Accreditation Adverse Actions

15. The Appeals Panel shall submit its recommendation to the ACGME Board within 20 days of the hearing. The ACGME Board shall act on the appeal at its next regularly scheduled meeting.

16. The decision of the ACGME Board in this matter shall be final. There is no provision for further appeal.

17. The President and Chief Executive Officer of the ACGME shall, within 15 days of the final decision, notify the appellant of the decision of the ACGME Board.

18. The appellant is fully responsible for the Appeal Fee as set by the ACGME. Expenses of the Appeals Panel members and the associated administrative costs shall be shared equally by the appellant and the ACGME.

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21.00 The Recognition Process

Recognition is additional acknowledgment, supplemental to accreditation, for identified elements or categories of a Sponsoring Institution or program. Recognition is conferred through a voluntary process of evaluation and review based on published recognition standards. ACGME recognition is overseen by a Recognition Committee. Sponsoring Institutions or programs with ACGME recognition must be accredited by the ACGME.

The Recognition Committee may confer a recognition status to Sponsoring Institutions or programs that is different from its accreditation status, and establish processes related to the same.

21.10 Osteopathic Recognition Application Process

Applications for Osteopathic Recognition of an ACGME-accredited specialty, subspecialty, sub-subspecialty, combined program not holding a status of Probationary Accreditation are initiated in the Accreditation Data System (ADS) by the program director or designated institutional official (DIO) of the program's ACGME-accredited Sponsoring Institution. The program director is responsible for designation in ADS of a Director of Osteopathic Education, who may be the program director or another member of the osteopathic faculty. The Director of Osteopathic Education is responsible for completion of the application and preparation for submission. The program director shall submit the application for review in ADS by the DIO. The DIO is responsible for submission of the completed Osteopathic Recognition application to the ACGME through ADS.

The Osteopathic Recognition Committee may confer a recognition status effective date that is the date of the decision or retroactive to the beginning of the academic year.

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21.00 The Recognition Process

21.20 Application of a Previously Recognized Sponsoring Institution or Program

If a Sponsoring Institution or program applies for recognition within two years of the effective date of a previous Recognition Withdrawn, the recognition history of the previous recognition action shall be included and considered by the Recognition Committee as a component of the application The Sponsoring Institution or program shall include a statement addressing each previous citation(s). The Recognition Committee will consider whether the application demonstrates substantial compliance with previous areas of non-compliance in conferring the recognition decision.

A Sponsoring Institution and program may only apply for Recognition after 12 months of the effective date of Voluntary Recognition Withdrawn.

21.21 Process for Review of the Application for Recognition

A Recognition Committee will determine whether a site visit is required prior to review of an application submitted for recognition.

A recognition site visit is not required prior to the review of an application for Osteopathic Recognition. The Osteopathic Recognition Committee shall consider the following information prior to conferring a recognition decision:

a. the recognition application as submitted;

b. the recognition history of the program, as applicable;

c. public information deemed reliable;

d. correspondence pertinent to the review; and,

e. other information, as requested by the Recognition Committee.

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21.00 The Recognition Process

21.20 The Recognition Application Process

21.23 Recognition Status Options for Application

The recognition status decision of Recognition Committee on applications will be based on the demonstration of substantial compliance with the applicable Recognition Requirements. The following actions are available for applications of Sponsoring Institutions and programs:

a. Recognition Withheld (Policies 22.10-22.12)

b. Initial Recognition (Policies 22.20-22.21)

21.24 Recognition Effective Date

A Recognition Committee may confer an effective date of Initial Recognition that is the date of the decision, beginning of the next academic year, or retroactive to the beginning of the academic year during which the decision is made.

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21.30 The Recognition Site Visit

The recognition process for Sponsoring Institutions and programs includes site visits to address compliance with the Recognition Requirements, as applicable. All recognition site visits for Sponsoring Institutions and programs are performed by Field Representatives who are employed by the ACGME.

Recognition site visits are conducted by individual Field Representatives or by a team made up of Field Representatives. In certain circumstances, the site visit team may include peer representatives.

21.31 The Recognition Site Visit Scheduling Process

Sponsoring Institutions and programs with an approximate recognition site visit date in the Accreditation Data System (ADS) may be scheduled for a site visit. ACGME Field Activities staff members shall initiate the scheduling process in collaboration with the Sponsoring Institution or program to determine a date for the visit. Once a date for the visit is determined, a Site Visit Announcement letter shall be sent confirming the date(s) of the visit, assigned Field Representative(s), and other information to prepare for the visit. Site visits may be “announced” or “unannounced.”

21.32 Preparation for a Recognition Site Visit

The Site Visit Announcement letter contains instructions to update ADS in preparation for the site visit, as well as other information about the day of the visit. The Field Representative(s) will communicate directly with the Sponsoring Institution or program about the site visit interview schedule. Field Representatives are provided with information from ADS regarding the Sponsoring Institution and program to be visited, as well as other information in preparation for the site visit.

21.33 Day of the Recognition Site Visit

During a Sponsoring Institution or program site visit, Field Representatives shall conduct interviews. Interviewees for an Osteopathic Recognition site visit shall include but not be limited to the designated institutional official, the program director(s), the Director of Osteopathic Education, coordinators, osteopathic faculty members, administrative staff members, and designated residents/fellows. Interviews can take place in person and/or remotely using audio/audio-visual technology.

21.34 After the Recognition Site Visit

Field Representative(s) shall prepare a Site Visit Report after each site visit, which shall be submitted to the Recognition Committee or to the President and Chief Executive Officer of the ACGME.

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21.40 Recognition of Sponsoring Institutions with Non-Standard Training Programs for J-1 Visa Sponsorship

ACGME recognition of Sponsoring Institutions with Non-Standard Training ("NST") programs provides approval and oversight of advanced clinical training opportunities in the United States for physicians whose J-1 visas are sponsored by the Educational Commission for Foreign Medical Graduates through the Exchange Visitor Program of the United States Department of State (22 CFR §62.27(e)(1); 22 CFR §62.27(e)(4)(i)).

Recognition for Sponsoring Institutions is provided by the Institutional Review Committee. Effective July 1, 2023, Sponsoring Institutions must be recognized by ACGME to enroll NST trainees in NST programs.

When the ACGME newly designates a specialty or subspecialty in which accreditation will be offered, Sponsoring Institutions may enroll NST trainees in NST programs in the same area of clinical focus for a period of three years after Board approval and the publication of ACGME Program Requirements for the specialty or subspecialty. In all other circumstances, Sponsoring Institutions may not offer NST programs in areas of clinical focus for which ACGME specialty or subspecialty accreditation or American Board of Medical Specialties member board certification is available.

22.00 Recognition and Administrative Actions

a. The following recognition and administrative status options may be conferred on Sponsoring Institutions and programs:

- Recognition Withheld (Policies 22.10-22.12)
- Initial Recognition (Policies 22.20-22.21)
- Initial Recognition with Warning (Policies 22.30-22.31)
- Continued Recognition without Outcomes (Policies 22.40-22.41)
- Continued Recognition (Policies 22.50-22.51)
- Continued Recognition with Warning (Policies 22.60-22.61)
- Probationary Recognition (Policies 22.70-22.71)
- Withdrawal of Recognition (Policy 22.80)
- Voluntary Withdrawal of Recognition (Policies 22.90-22.91)
- Administrative Withdrawal of Recognition (Policy 22.100)

b. The following statuses are adverse actions and may be appealed:

- Recognition Withheld (Policies 22.10-22.12)
- Probationary Recognition (Policies 22.70-22.71)
- Withdrawal of Recognition (Policy 22.80)

c. Sponsoring Institutions and programs may not appeal other recognition actions (e.g., citations, warnings).

d. Following review of a Sponsoring Institution, a Letter of Notification that includes the action(s) of the Recognition Committee, shall be sent to the Designated Institutional Official

(DIO). Following review of a program, the program director shall likewise receive a Letter of Notification, with a copy sent to the DIO.

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22.00 Recognition and Administrative Actions

22.10 Recognition Withheld

Recognition shall be withheld when a Recognition Committee determines that an application for recognition of a Sponsoring Institution or program does not demonstrate substantial compliance with the applicable Recognition Requirements. Recognition Withheld is an adverse recognition decision and is subject to appeal (Policy 22.00.b.).

22.11 Reapplication following Recognition Withheld

A Sponsoring Institution or program may reapply for recognition after receiving a status of Recognition Withheld. If a Sponsoring Institution or program reapplies for recognition within two years of the effective date of Recognition Withheld, the history of the previous recognition action shall be included as part of the review. The Sponsoring Institution or program shall include a statement addressing each previous citation with the new application.

Osteopathic Recognition Programs Only

The program must notify all current residents/fellows and anyone that has interviewed for a designated osteopathic position, in writing. A copy of this notification must be uploaded into ADS within 50 days of Recognition Withheld decision notification.

22.12 Site Visit Prior to Next Review by the Recognition Committee following Recognition Withheld

A recognition site visit may be required for recognition applications following a decision of Recognition Withheld.

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22.20 Initial Recognition

Initial Recognition is a developmental period of recognition, following demonstration of substantial compliance with the applicable Recognition Requirements after submission of an application. Sponsoring Institutions and programs with a status of Initial Recognition must demonstrate substantial compliance with all Recognition Requirements (Core, Detail, Outcome).

A status of Initial Recognition may be conferred when separately recognized Sponsoring Institutions or programs merge, or when a recognized Sponsoring Institution or program has been so altered that in the judgment of a Recognition Committee it is the equivalent of a new Sponsoring Institution or program.

A Recognition Committee may confer an effective date of Initial Recognition that is the date of the decision, beginning of the next academic year, or retroactive to the beginning of the academic year during which the decision is made.

22.21 Review of a Sponsoring Institution or Program with a Status of Initial Recognition

a. Timing of the Recognition Site Visit

   A review shall be conducted following a recognition site visit within approximately two years of the effective date of Initial Recognition.

b. Information used by the Recognition Committee to confer a status decision may include but is not limited to:

   1. an updated recognition application;
   2. recognition Site Visit Report;
   3. recognition history of the Sponsoring Institution and/or program, as applicable;
   4. correspondence pertinent to the review;
   5. public information deemed reliable; and,
   6. additional information, as requested by the Recognition Committee.

c. Based on consideration of the information described in (b), the following options are available *prior* to conferring a recognition status include:

   1. request a recognition site visit; or,
   2. request additional information.

22.00 Recognition and Administrative Actions

22.20 Initial Recognition

22.21 Review of a Sponsoring Institution or Program with a Status of Initial Recognition

d. Available recognition status options:

1. Initial Recognition with Warning (Policies 22.30-22.31)

2. Continued Recognition without Outcomes (Policies 22.40-22.41)

3. Continued Recognition (Policies 22.50-22.51)

4. Withdrawal of Recognition (Policy 22.80)

e. Available action options *when* conferring a recognition status include:

1. issue, extend, or resolve a citation(s);

2. issue an Area for Improvement(s) *(not applicable to status of Recognition Withheld)*; and,

3. request a progress report *(not applicable to status of Recognition Withheld)*.

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22.30 Initial Recognition with Warning

Following the developmental period of Initial Recognition, if a Sponsoring Institution or program fails to demonstrate substantial compliance with the applicable Recognition Requirements, a Recognition Committee may confer a status of Initial Recognition with Warning for a duration of one year.

If, after a recognition site visit, the Sponsoring Institution or program again fails to demonstrate substantial compliance, a Recognition Committee may confer a second year of Initial Recognition with Warning or Recognition Withdrawn.

If, after a second decision of Initial Recognition with Warning, and after a subsequent recognition site visit, the Sponsoring Institution or program fails to achieve substantial compliance with the applicable Recognition Requirements, a Recognition Committee shall confer the status of Withdrawal of Recognition.

Sponsoring Institutions and programs with a status of Initial Recognition with Warning must continue to demonstrate substantial compliance with all applicable Recognition Requirements (Core, Detail, Outcome).

The Recognition Committee shall confer an accreditation status effective date that is the date of the decision.

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22.00 Recognition and Administrative Actions

22.30 Initial Recognition with Warning

22.31 Review of a Sponsoring Institution or Program with a Status of Initial Recognition with Warning

a. Timing of Review by the Recognition Committee and Site Visit

A Sponsoring Institution or program shall be scheduled for review approximately one year after a status of Initial Recognition with Warning is conferred. A recognition site visit of the Sponsoring Institution or program must occur prior to this review. If a Sponsoring Institution or program is conferred with the status of Initial Recognition with Warning for a second year, the Sponsoring Institution or program shall be required to have a recognition site visit prior to the end of the second year.

The site visit may occur approximately one year after the status of Initial Recognition with Warning is conferred.

b. Information used by the Recognition Committee to confer a status decision may include but is not limited to:

1. an updated recognition application;
2. recognition Site Visit Report (if applicable);
3. history of the Sponsoring Institution and/or program, as applicable;
4. correspondence pertinent to the review;
5. public information deemed reliable; and,
6. additional information, as requested by the Recognition Committee.

c. Based on consideration of the information described in (b), the following options are available *prior* to conferring a recognition status include:

1. request a recognition site visit; or,
2. request additional information.

d. Available recognition status options:

1. Initial Recognition with Warning *(not an option for Sponsoring Institutions or programs that have had a status of Initial Recognition with Warning conferred twice)* (Policies 22.30-22.31)
2. Continued Recognition without Outcomes (Policies 22.40-22.41)
3. Continued Recognition (Policies 22.50-22.51)

22.00 Recognition and Administrative Actions

22.30 Initial Recognition with Warning

22.31 Review of a Sponsoring Institution or Program with a Status of Initial Recognition with Warning

4. Withdrawal of Recognition *(site visit required before conferring this status)* (Policy 22.80)

e. Available action options *when* conferring a recognition status include:

1. issue, extend, or resolve a recognition citation(s);

2. issue an Area for Improvement(s) *(not applicable to status of Withdrawal of Recognition)*; or,

3. request a progress report *(not applicable to status of Withdrawal of Recognition)*.

22.40 Continued Recognition without Outcomes

The recognition status of Continued Recognition without Outcomes shall be conferred on programs that demonstrate substantial compliance with the applicable Recognition Requirements after a period of Initial Recognition.

Additional Osteopathic Recognition-Specific Criteria

For programs with Osteopathic Recognition, a status of Continued Recognition without Outcomes may be conferred if a program has not had designated osteopathic residents/fellows or a designated osteopathic resident/fellow that has completed the program since recognition was initially conferred.

Programs with a status of Continued Recognition without Outcomes are subject to recognition citations under Recognition requirements categorized as “Core” and “Detail.” Although programs with a status of Continued Recognition without Outcomes are not subject to recognition citations under “Outcome” requirements, they are expected to comply with those requirements, upon progression to the status of Continued Recognition.

A Recognition Committee shall confer an effective date of recognition that is the date of the decision.

22.41 Review of a Sponsoring Institution or Program with a Status of Continued Recognition without Outcomes

a. Timing of the Review by the Recognition Committee and Site Visit

The Sponsoring Institution or program will be scheduled for an annual review by the Recognition Committee. In rare circumstances, the Recognition Committee may defer the review of a Sponsoring Institution or program in a given academic year.

A Recognition site visit may be scheduled approximately every 10 years from the effective date of initially being conferred with Continued Recognition without Outcomes. At the discretion of the Recognition Committee, a recognition site visit may be scheduled more frequently.

b. Information used by the Recognition Committee to confer a status decision may include but is not limited to:

1. review of annual recognition data;
2. recognition Site Visit Report *(if applicable)*;
3. recognition history of the Sponsoring Institution or program, as applicable;
4. correspondence pertaining to the review;
5. public information deemed reliable; and,
6. additional information, as requested by the Recognition Committee.

22.00 Recognition and Administrative Actions

22.40 Continued Recognition without Outcomes

22.41 Review of a Program with a Status of Continued Recognition without Outcomes

c. Based on consideration of the information described in (b), the following options are available *prior* to conferring a recognition status include:

   1. request a recognition site visit; or,

   2. request additional information.

d. Available recognition status options

   Programs with a status of Continued Recognition without Outcomes must not maintain the status longer than the length of the educational program plus one year, at which time the Recognition Committee must confer one of the following statuses:

   1. Continued Recognition (Policies 22.50-22.51)

   2. Continued Recognition with Warning (Policies 22.60-22.61)

   3. Probationary Recognition *(site visit required before conferring this status)* (Policies 22.70-22.71)

   4. Withdrawal of Recognition *(site visit required before conferring this status)* (Policy 22.80)

e. Available action options *when* conferring a recognition status include:

   1. issue, extend, or resolve a recognition citation(s);

   2. issue an Area for Improvement(s) *(not applicable for programs with a status of Probationary Recognition or Withdrawal of Recognition)*; or,

   3. request a progress report *(not applicable for programs with a status of Withdrawal of Recognition)*.

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22.50 Continued Recognition

A Recognition Committee may confer a status of Continued Recognition on a Sponsoring Institution or program that upon review has demonstrated substantial compliance with the applicable Recognition Requirements.

Sponsoring Institutions and programs holding a status of Continued Recognition are subject to recognition review of Recognition requirements categorized as “Core” and “Outcome.”

A Recognition Committee shall confer an effective date of recognition that is the date of the decision.

22.51 Review of a Sponsoring Institution or Program with a Status of Continued Recognition

a. Timing of review by the Recognition Committee and Site Visit

   The Sponsoring Institution or program will be scheduled for an annual review by the Recognition Committee. In rare circumstances, the Recognition Committee may defer the review of a Sponsoring Institution or program in a given academic year.

   A recognition site visit may be scheduled approximately every 10 years from the effective date of initially being conferred with Continued Recognition or Continued Recognition without Outcomes. At the discretion of the Recognition Committee, a recognition site visit may be scheduled more frequently.

b. Information used by the Recognition Committee to confer a status decision may include but is not limited to:

   1. review of annual recognition data;
   2. recognition Site Visit Report (if applicable);
   3. recognition history of the Sponsoring Institution and/or program, as applicable;
   4. correspondence pertinent to the review;
   5. public information; and,
   6. additional information, as requested by the Recognition Committee.

c. Based on consideration of the information described in (b), the following options are available *prior* to conferring a recognition status include:

   1. request a recognition site visit; or,
   2. request additional information.

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22.00 Recognition and Administrative Actions

22.50 Continued Recognition

22.51 Review of a Sponsoring Institution or Program with a Status of Continued Recognition

d. Available recognition status options:

1. Continued Recognition (Policies 22.50-22.51)

2. Continued Recognition with Warning (Policies 22.60-22.61)

3. Probationary Recognition *(site visit required before conferring this status)* (Policies 22.70-22.71)

4. Withdrawal of Recognition *(site visit required before conferring this status)* (Policy 22.80)

e. Available action options *when* conferring a recognition status are:

1. issue, extend, or resolve a recognition citation(s);

2. issue an Area for Improvement(s) *(not applicable for Sponsoring Institutions or programs with a status of Probationary Recognition or Withdrawal of Recognition)*; or,

3. request a progress report *(not applicable for status of Withdrawal of Recognition)*.

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22.60 Continued Recognition with Warning

A Recognition Committee may confer a status of Continued Recognition with Warning if it has determined that a Sponsoring Institution or program has areas of non-compliance with the applicable Recognition Requirements that may jeopardize its recognition status.

Sponsoring Institutions and programs holding a status of Continued Recognition with Warning are subject to recognition review of all Recognition Requirements (Detail, Core, and Outcome).

A Recognition Committee shall confer an effective date of recognition that is the date of the decision.

22.61 Review of a Sponsoring Institution or Program with a Status of Continued Recognition with Warning

a. Timing of review by the Recognition Committee and Site Visit

   The Sponsoring Institution or program will be scheduled for an annual review by the Recognition Committee. In rare circumstances, the Recognition Committee may defer the review of a Sponsoring Institution or program in a given academic year.

   A recognition site visit may be scheduled approximately every 10 years from the effective date of initially being conferred with Continued Recognition or Continued Recognition without Outcomes. At the discretion of the Recognition Committee, a recognition site visit may be scheduled more frequently.

b. Information used by the Recognition Committee to confer a status decision may include but is not limited to:

   1. review of annual recognition data;
   2. recognition Site Visit Report (if applicable);
   3. recognition history of the Sponsoring Institution and/or program, as applicable;
   4. correspondence pertinent to the review;
   5. public information; and,
   6. additional information, as requested by the Recognition Committee.

c. Based on consideration of the information described in (b), the following options are available *prior* to conferring a recognition status include:

   1. request a recognition site visit; or,
   2. request additional information.

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22.00 Recognition and Administrative Actions

22.60 Continued Recognition with Warning

22.61 Review of a Sponsoring Institution or Program with a Status of Continued Recognition with Warning

d. Available recognition status options are:

1. Continued Recognition (Policies 22.50-22.51)

2. Continued Recognition with Warning (Policies 22.60-22.61)

3. Probationary Recognition *(site visit required before conferring this status)* (Policies 22.70-22.71)

4. Withdrawal of Recognition *(site visit required before conferring this status)* (Policy 22.80)

e. Available action options *when* conferring a recognition status are:

1. issue, extend, or resolve a recognition citation(s);

2. issue an Area for Improvement(s) *(not applicable for Sponsoring Institutions or programs with a status of Probationary Recognition or Withdrawal of Recognition)*; or,

3. request a progress report *(not applicable for Sponsoring Institutions or programs with a status of Probationary Recognition or Withdrawal of Recognition)*.

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22.70 Probationary Recognition

A Recognition Committee may confer a status of Probationary Recognition if it has determined that a Sponsoring Institution or program has failed to demonstrate substantial compliance with the applicable Recognition Requirements confirmed by the findings of a recognition site visit. Probationary Recognition is an adverse recognition decision and is subject to appeal (Section 19.00).

Sponsoring Institutions and programs holding a status of Probationary Recognition are subject to recognition review of all Recognition Requirements (Detail, Core, and Outcome).

Probationary status of a Sponsoring Institution or program shall not exceed two consecutive annual reviews, at which point the Sponsoring Institution or program must achieve a status of Continued Recognition or Continued Recognition with Warning, or its recognition shall be withdrawn.

Osteopathic Recognition Programs Only:

All applicants invited to interview with the program and any residents/fellows accepted into program with a status of Probationary Recognition must be notified in writing of the probationary status.

A Recognition Committee shall confer an effective date of recognition that is the date of the decision.

22.00 Recognition and Administrative Actions

22.70 Probationary Recognition

22.71 Review of a Sponsoring Institution or Program with a Status of Probationary Recognition

a. Timing of review by the Recognition Committee and Site Visit

   Sponsoring Institutions and programs will be reviewed annually, and a site visit must be scheduled prior to each review while on Probationary Recognition. A Sponsoring Institution's or program's time on Probationary Recognition shall not exceed two consecutive annual reviews.

b. Information used by the Recognition Committee to confer a status decision may include but is not limited to:

   1. review of annual recognition data;
   2. recognition Site Visit Report;
   3. recognition history of the Sponsoring Institution and/or program, as applicable;
   4. correspondence pertinent to the review;
   5. public information; and,
   6. additional information, as requested by the Recognition Committee.

c. Based on consideration of the information described in (b), the following options are available *prior* to conferring a recognition status include:

   1. request a recognition site visit; or,
   2. request additional information.

d. Available recognition status options include:

   1. Continued Recognition (Policies 22.50-22.51)
   2. Continued Recognition with Warning (Policies 22.60-22.61)
   3. Probationary Recognition *(site visit required before conferring this status)* (Policies 22.70-22.71)
   4. Withdrawal of Recognition *(site visit required before conferring this status)* (Policy 22.80)

22.00 Recognition and Administrative Actions

22.70 Probationary Recognition

22.71 Review of a Sponsoring Institution or Program with a Status of Probationary Recognition

e. Available action options *when* conferring a recognition status include:

1. issue, extend, or resolve a recognition citation(s);

2. issue an Area for Improvement(s) *(not applicable for Sponsoring Institutions or programs with a status of Probationary Recognition or Withdrawal of Recognition)*; or,

3. request a progress report *(not applicable for Sponsoring Institutions or programs with a status of Withdrawal of Recognition)*.

22.80 Withdrawal of Recognition

A Recognition Committee may confer a status of Withdrawal of Recognition if it has determined that a Sponsoring Institution or program has failed to demonstrate substantial compliance with the applicable Recognition Requirements based upon the findings of a recognition site visit. Withdrawal of Recognition is an adverse recognition decision and is subject to appeal (Policy 22.00.b.).

For Sponsoring Institutions and programs with Osteopathic Recognition:

No new residents or fellows may enter a designated osteopathic position in the program regardless of the intent to appeal.

All applicants invited to interview with the program, accepted into the program, and are enrolled in designated osteopathic positions in a program with a status of Withdrawal of Recognition must be notified in writing of the withdrawal and its effective date.

The Sponsoring Institution of a program with a status of Withdrawal of Recognition should facilitate the transfer of current and accepted osteopathic designated residents and fellows if they wish to be placed in other ACGME-accredited programs with Osteopathic Recognition.

A copy of the correspondence provided to the residents or fellows must be uploaded into the Accreditation Data System within 50 days of Withdrawal of Recognition decision notification.

The effective date of the Withdrawal of Recognition shall be determined by the Recognition Committee. ACGME-accredited programs with Osteopathic Recognition may complete the current academic year, and, at the discretion of the Recognition Committee, one additional academic year.

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22.90 Voluntary Withdrawal of Recognition

Both Sponsoring Institutions and programs may request Voluntary Withdrawal of Recognition if the applicable Recognition Committee has not already conferred a status of Recognition Withdrawn. The recognition status of the Sponsoring Institution or program may then only be altered through an appeal.

A Voluntary Withdrawal of Recognition request for a Sponsoring Institution or program must be submitted by the designated institutional official through the Accreditation Data System (ADS) after approval by the Graduate Medical Education Committee. Sponsoring Institutions or programs may not request reversal of the action after it has been processed by the Recognition Committee (regardless of the proposed effective date.

The requested effective date of Voluntary Withdrawal of Recognition for programs must coincide with the end of the current academic year.

Sponsoring Institutions and programs may reapply for recognition only after a period of 12 months following the effective date of a Voluntary Withdrawal of Recognition.

22.91 Responsibilities of the Sponsoring Institution or Program upon a Request for Voluntary Withdrawal

When a request for Voluntary Withdrawal for Recognition is made, Sponsoring Institutions and programs must:

a. notify all applicants invited to interview with the program, accepted into the program, and anyone enrolled in a designated osteopathic position, in writing. This notification must be provided to the ACGME Executive Director of the Osteopathic Recognition Committee at the time the voluntary withdrawal request is made in ADS; and,

b. support the transfer of designated osteopathic residents/fellows who seek to transfer to another ACGME-accredited program with Osteopathic Recognition and notify them of this support in writing; this notification must also be provided to the ACGME Executive Director of the Osteopathic Recognition Committee at the time the voluntary withdrawal request is made in ADS.

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22.100 Administrative Withdrawal of Recognition

If recognition is withdrawn from a Sponsoring Institution or program, as applicable to the recognition, a status of Administrative Withdrawal of Recognition will be automatically conferred by the Recognition Committee. The recognition status of the Sponsoring Institution or program may be altered only through an appeal.

The effective date of Administrative Withdrawal of Recognition will coincide with effective date of the recognition decision conferred by the applicable Recognition Committee.

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23.00 Appeals of Adverse Recognition Actions

23.10 Adverse Recognition Actions

The following recognition actions are considered adverse and may be appealed under this section with the exception of an adverse action made by the ACGME Board under the Alleged Egregious Violation Event policy (Policy 24.00).

- Recognition Withheld (Policies 22.10-22.12)
- Probationary Recognition (Policies 22.70-22.71)
- Withdrawal of Recognition (Policy 22.80)

23.20 Procedures for an Adverse Recognition Action

a. When a Recognition Committee confers an adverse action, it shall issue a Letter of Notification which shall include the citations that form the basis for the adverse action and a copy of the Site Visit Report, if applicable.

b. For an adverse action for a Sponsoring Institution, the Letter of Notification shall be sent to the designated institutional official (DIO). For an adverse action for a program, the letter of notification will be sent to the program director with a copy to the DIO. Sponsoring Institutions and programs may appeal adverse actions; otherwise, an adverse action is final.

c. Procedures Specific to Osteopathic Recognition

1. All applicants invited to interview with the program, accepted into the program, and are enrolled in designated osteopathic positions in a program with an adverse recognition status must be notified in writing of the status and its effective date.

2. No new residents or fellows may enter a designated osteopathic position in a program with the status of Withdrawal of Recognition regardless of the intent to appeal.

3. The Sponsoring Institution of a program with a status of Withdrawal of Recognition should facilitate the transfer of current and accepted osteopathic designated residents and fellows if they wish to be placed in other ACGME-accredited programs with Osteopathic Recognition.

4. A copy of the correspondence provided to the residents or fellows must be uploaded into ADS within 50 days of an adverse recognition decision notification.

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23.30 Procedures for Appeal of Adverse Recognition Actions

If a Recognition Committee confers an adverse action, the Sponsoring Institution or program may request a hearing before an Appeals Panel. If a written request for such a hearing is not received by the President and Chief Executive Officer of the ACGME within 30 days following receipt by the Sponsoring Institution or program of the Letter of Notification of the adverse recognition action, the action of the Recognition Committee shall be deemed final and not subject to further appeal.

a. If a hearing is requested, an Appeals Panel shall be appointed according to the following procedures:

    1. The ACGME shall maintain a list of qualified persons as potential Appeals Panel members.

    2. For a given hearing, the Sponsoring Institution or program shall receive a copy of the list of potential Appeals Panel members and shall have an opportunity to delete a maximum of one-third of the names from this list. Within 15 days of receipt of this list, the Sponsoring Institution or program shall submit its revised list as directed in the letter acknowledging the appeal.

    3. A three-member Appeals Panel shall be constituted by the ACGME from among the remaining names on the list.

b. When a hearing is requested, the following policies and procedures shall apply:

    1. When a Sponsoring Institution or program requests a hearing before an Appeals Panel, the Sponsoring Institution or program holds the recognition status determined by the Recognition Committee with the addition of the term “under appeal for recognition.” This status shall remain in effect until the ACGME makes a final determination on the recognition status of the Sponsoring Institution or program following the appeal process.

    2. Hearings conducted in conformity with these procedures shall be held at a time and place to be determined by the ACGME. At least 25 days prior to its hearing, the Sponsoring Institution or program shall be notified of the time and place of the hearing.

    3. The Sponsoring Institution or program shall be given the documents comprising the record of the Recognition Committee’s action.

    4. The documents comprising the record of the Recognition Committee’s action, together with oral and written presentations to the Appeals Panel, shall be the basis for the final recommendations of the Appeals Panel.

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23.00 Appeals of Adverse Recognition Actions

23.30 Procedures for Appeal of Adverse Recognition Actions

5. The Appeals Panel shall meet to review the written record and receive the presentations. The Recognition Committee shall be notified of the hearing and a representative of the Recognition Committee shall attend the hearing.

6. Proceedings before an Appeals Panel are not of an adversarial nature as typical in a court of law, but rather provide an administrative mechanism for peer review of the recognition decision. The Appeals Panel shall not be bound by technical rules of evidence usually employed in legal proceedings.

7. The appellant may be represented by no more than five individuals at the hearing.

8. Presentations shall be limited to clarifications of the record focusing on information addressing:

   a) compliance with the applicable published Recognition Requirements at the time of the Recognition Committee's review and conferral of the adverse action, and

   b) the review of the Sponsoring Institution or program according to the applicable procedures.

9. Presentations may include written and oral elements. Any information, including presentations and audio/visual and written materials, must be provided to the ACGME a minimum of 10 business days prior to the hearing.

   The order of presentations shall be:

   a) The appellant shall make an initial presentation to the Appeals Panel, which shall be limited to two hours.

   b) The Recognition Committee representative shall make a presentation to the Appeals Panel, which shall be limited to one hour.

   c) The appellant may make a presentation to the Appeals Panel in response to the Recognition Committee representative's presentation, which shall be limited to one hour.

   d) The Appeals Panel may ask questions of the appellant and/or the Recognition Committee representative for up to one hour.

   e) The appellant may make a closing statement, which shall be limited to fifteen minutes.

10. The Appeals Panel shall not consider any changes in the Sponsoring Institution or program or descriptions of the Sponsoring Institution or program that were not in the record at the time the Recognition Committee reviewed it and conferred the adverse action.

11. The appellant shall not communicate with the Appeals Panel before or after the hearing.

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23.00 Appeals of Adverse Recognition Actions

23.30 Procedures for Appeal of Adverse Recognition Actions

12. The Appeals Panel shall make recommendations to the ACGME Board as to whether substantial, credible, and relevant evidence exists to support the action taken by the Recognition Committee in the matter under appeal. The Appeals Panel shall, in addition, make recommendations as to whether there has been substantial compliance with the administrative procedures that govern the recognition process.

13. The Appeals Panel may recommend upholding the Recognition Committee's decision or restoring the Sponsoring Institution or program to its previous recognition status or, in the case of Recognition Withheld, conferring Initial Recognition.

14. The Appeals Panel shall submit its recommendation to the ACGME Board within 20 days of the hearing. The ACGME Board shall act on the appeal at its next regularly scheduled meeting.

15. The decision of the ACGME Board in this matter shall be final. There is no provision for further appeal.

16. The President and Chief Executive Officer of the ACGME shall, within 15 days of the final decision, notify the appellant of the decision of the ACGME Board.

17. The appellant is fully responsible for the Appeal Fee as set by the ACGME. Expenses of the Appeals Panel members and the associated administrative costs shall be shared equally by the appellant and the ACGME.

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24.00 Procedure for Alleged Egregious Events

24.10 Alleged Egregious Events

a. The occurrence of an alleged egregious accreditation violation affecting one or more Sponsoring Institutions or programs must be reported to the ACGME President and Chief Executive Officer. Individuals involved in graduate medical education have a professional responsibility to report such matters promptly.

b. Upon receipt of a report of an alleged egregious accreditation violation, the ACGME President and Chief Executive Officer shall initiate an investigation to determine credibility, degree of urgency, and course of action. The investigation may include:

   1. an accreditation site visit;

   2. a request for information from the Sponsoring Institution(s) and/or program(s); and/or,

   3. other methods of investigation.

c. Upon investigation, the ACGME President and Chief Executive Officer may:

   1. refer the matter to the appropriate Review Committee(s) for action in the judgment of the Review Committee(s);

   2. refer the matter to the appropriate Review Committee(s) with recommendation(s) for action;

   3. request one or more status reports from the Sponsoring Institution and/or program;

   4. otherwise address the matter, at the ACGME President and Chief Executive Officer's discretion; and/or,

   5. initiate consultation, as described in d. below, that may lead to an accreditation decision by the ACGME Board.

d. When the President and Chief Executive Officer of the ACGME determines that the matter may require an accreditation decision by the ACGME Board, the following procedures shall be followed:

   1. The President and Chief Executive Officer of the ACGME shall consult with the ACGME Board Chair and the Chair of the Council of Review Committee Chairs.

      Upon consultation, the President and Chief Executive Officer of the ACGME may:

      a) conduct an investigation as described in above,

      b) proceed as described in c.1.-5. Above; and/or,

24.00 Procedure for Alleged Egregious Events

24.10 Alleged Egregious Events

c) refer the matter to the Executive Committee of the ACGME Board for consideration at its next regular meeting, or at a meeting specifically convened to address the matter.

2. If the matter is referred to the Executive Committee, the Executive Committee shall make a recommendation to the ACGME Board for its final disposition of the matter, which may include, without limitation, a change in accreditation status as provided in Policy 19.00, or other action.

3. If an adverse accreditation decision is conferred by the ACGME Board, the Sponsoring Institution(s) or program(s) may request reconsideration by the ACGME Board. This request must be made in writing to the President and Chief Executive Officer of the ACGME within 30 days of receipt of written notification of the decision. The result of the reconsideration shall be final.

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25.00 ACGME Policy and Procedures to Address Extraordinary Circumstances

The ACGME may invoke the Extraordinary Circumstances policy in response to circumstances that significantly disrupt the ability of a Sponsoring Institution and/or its program(s) to support graduate medical education in compliance with applicable ACGME requirements. Extraordinary Circumstances may impact a Sponsoring Institution or program or have a regional or national impact. Examples of extraordinary circumstances include, but are not limited to, abrupt closure of a hospital or other essential clinical site resulting from a natural disaster; a catastrophic loss of funding; acts of terrorism or cyberterrorism; and loss of infrastructure or acute and prolonged health system disruption during epidemics or pandemics. The ACGME shall consider invocation of the Extraordinary Circumstances policy (1) at the request of a Sponsoring Institution's or program's designated institutional official (2) in response to verified public information, or (3) on the basis of other information received by the ACGME.

25.10 ACGME Declaration of Extraordinary Circumstances

Upon receipt of information that suggests a potential Extraordinary Circumstance, the ACGME President and Chief Executive Officer may initiate an investigation to determine credibility, degree of urgency, and/or course of action, or proceed immediately to consideration of declaration of extraordinary circumstance.

An investigation may include:

a. an accreditation site visit;

b. a request for information from the Sponsoring Institution and/or programs(s); and/or,

c. other methods of inquiry, including, but not limited to, a site visit that may include exchange of information that addresses the continuation of residents'/fellows' educational experiences in compliance with applicable ACGME Requirements.

If the ACGME President and Chief Executive Officer, in consultation with the ACGME Board Chair, determines that a Sponsoring Institution's or program's ability to support graduate medical education in compliance with applicable ACGME Requirements has been significantly disrupted, the ACGME President and Chief Executive Officer shall invoke the Extraordinary Circumstances policy. Based on the severity and generalizability of the Extraordinary Circumstance, the ACGME administration may recommend emergency standards and/or other procedures to the ACGME Executive Committee and the ACGME Board for approval. Programs operating under Extraordinary Circumstances must comply with these ACGME Extraordinary Circumstances requirements as applicable.

Upon invocation of the Extraordinary Circumstances policy, a notice may be posted on the ACGME website with information relating to the ACGME's response to the extraordinary circumstances.

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25.20 Sponsoring Institutions

When the Extraordinary Circumstances policy is invoked, the designated institutional official (DIO), or designee(s), on behalf of the affected Sponsoring Institution or program(s), shall:

a. contact the ACGME President and Chief Executive Officer, or designee, to provide preliminary information regarding any major changes to the Sponsoring Institution and its programs resulting from the extraordinary circumstances within 10 days of the invocation of the policy;

b. provide a plan describing the continuation of residents'/fellows' educational experiences and any major changes to the Sponsoring Institution and its programs, consistent with the applicable ACGME Requirements, to the ACGME President and Chief Executive Officer within 30 days of the invocation of the policy, unless another due date is approved by the ACGME;

c. as needed, arrange timely reassignment of residents and fellows, including their temporary or permanent transfers to other ACGME-accredited programs to ensure they can continue their education;

d. ensure that residents and fellows are prospectively informed of the estimated duration of any temporary transfer to another ACGME-accredited program; and,

e. ensure that residents/fellows continually receive timely information regarding reassignments, transfer arrangements, and/or major changes to the Sponsoring Institution or its programs.

25.30 Program Expectations and Reporting Requirements

Programs operating under the Extraordinary Circumstances policy must continue to assess residents/fellows in all six Core Competencies, and such assessments must form the basis for decisions regarding promotion to subsequent appointment levels or satisfaction of requirements for program completion. Programs must follow the principles of competency-based medical education to make determinations regarding the assessment of the residents'/fellows' readiness to progress to the next year of education and training or to enter autonomous practice. Individualized learning plans must be utilized to ensure adequate progression through the required elements of the program.

The Review Committee and/or the ACGME, as applicable, will inform the Sponsoring Institution(s) and program(s) of:

1) reporting requirements related to the impact of the extraordinary circumstance on the educational program(s) and the progress of the program(s) toward resuming normal operations; and,

2) the maximum length of time the program(s) may operate under extraordinary circumstances. At the end of this time period, the program(s) must demonstrate substantial compliance with the applicable ACGME Requirements. At the discretion of the Review Committee, a site visit may be conducted and, if the Review Committee does not determine substantial compliance with ACGME Requirements, the program(s) will be subject to an adverse accreditation action including, but not limited to, Withdrawal of Accreditation.

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25.40 Resident/Fellow Transfers and Program Changes

Sponsoring Institutions and programs must minimize disruption to resident/fellow education due to extraordinary circumstances and must consider the preferences of residents/fellows when arranging temporary or permanent transfers to other ACGME-accredited programs.

Programs must appoint transferring residents/fellows to approved positions and may request temporary or permanent increases in resident/fellow complement from their respective ACGME Review Committees through the Accreditation Data System (ADS). Under extraordinary circumstances, the ACGME Review Committees shall expedite their review of requests for temporary or permanent complement increases.

An ACGME Review Committee shall expedite review of a program's request to add or delete participating sites or to change its educational format if the request is associated with a declaration of extraordinary circumstances.

At its discretion, the ACGME may determine a schedule for expedited review of applications for new programs that intend to accept transferring residents/fellows under extraordinary circumstances. If applications will be reviewed on an expedited basis, notice of the expedited review, including information about submission due date(s), shall be provided on the ACGME website.

25.50 Site Visits

Upon invocation of the Extraordinary Circumstances policy, the ACGME may determine that one or more accreditation site visits is required. Prior to the visit(s), the designated institutional official(s) shall receive notification of the advance information that will be required. This information, as well as information received by the ACGME during these accreditation site visits, may be used in the accreditation process (Policies 18.20-18.24; 21.30-21.34).

25.60 Notifying Public Entities

Depending on the nature and impact of the extraordinary circumstances, the ACGME President and Chief Executive Officer may communicate with relevant public entities

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26.00 ACGME Policy for Granting Rotation-Specific Clinical and Educational Work Hour Exceptions

Programs may apply to a Review Committee for a rotation-specific maximum 10 percent increase in the 80-hour per week clinical and educational work hour limit. Each Review Committee may decide that it will not consider any requests for exception. Information on whether a Review Committee grants an exception to the 80-hour limit can be found in the specialty-specific Program Requirements.

The Graduate Medical Education Committee must review and formally endorse a request for an exception under this policy. The endorsement must be indicated by the signature of the designated institutional official.

If approved, such an exception will be reviewed annually by the Review Committee.

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27.00 Procedures for Submission of Complaints Regarding Sponsoring Institutions and Programs

27.10 Complaints

The ACGME addresses allegations of non-compliance with accreditation or recognition requirements by Sponsoring Institutions and programs through its Complaints process. Individuals with issues regarding the performance of Sponsoring Institutions or programs shall initiate the investigation process by contacting the Office of Complaints. The ACGME shall determine if a submission shall be processed as a formal complaint.

Sponsoring Institutions and programs accredited or recognized by the ACGME are expected to comply with all applicable ACGME Requirements. The ACGME and its committees address only matters regarding compliance with ACGME requirements. The ACGME does not adjudicate disputes between individuals and Sponsoring Institutions or programs regarding Sponsoring Institution/program decisions about admission, appointment, contract, credit, promotion, or dismissal of faculty members, residents, or fellows.

The ACGME requires Sponsoring Institutions and programs to provide an educational and work environment in which residents and fellows can raise and resolve issues without fear of intimidation or retaliation.

27.11 Confidentiality of Individuals

The ACGME shall take steps to keep the identity of any individual(s) reporting potential non-compliance with requirements confidential, except when a complainant specifically waives the right to confidentiality or as required by law.

In some cases, an allegation is tied so closely to an individual that the Sponsoring Institution and/or program cannot provide a comprehensive response if they do not know the identity of that person. Under these circumstances, the ACGME may require a complainant's consent to disclose the complainant's identity in order to proceed with the Complaints process.

27.12 Confidentiality of Sponsoring Institutions and Programs' Responses to Complaints

The ACGME shall maintain confidentiality of a Sponsoring Institution's and/or program's response to a complaint submitted to the ACGME unless required by law.

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27.20 Submission of Complaints

Anyone having evidence of non-compliance with accreditation or recognition requirements by a Sponsoring Institution or program may submit a complaint to the ACGME. Complaints must be submitted in writing and should bear the name and address of the complainant(s). However, before a complaint is submitted, the complainant should first utilize all the institutional resources the Sponsoring Institution or program has available to report and resolve the issues unless there is a valid reason for not doing so. Allegations of non-compliance that occurred only prior to the current and preceding academic year should not be submitted. Exceptions shall be considered on a case-by-case basis.

27.30 Review and Recognition Committee Action for Formal Complaints

The committees shall review a complaint and the Sponsoring Institution or program response and shall determine whether the Sponsoring Institution or program was in substantial compliance with the applicable ACGME requirements. The committee may decide to take no further action or to process as described in Policies 19.00 and 22.00, which may include requesting additional information or an accreditation site visit.

Following consideration by a committee, the designated institutional official and, when applicable, the program director shall be informed, in writing, of the committee's decision in an official Letter of Notification. The Office of Complaints shall inform the complainant that a complaint has been reviewed by the relevant committee and share publicly available information about accreditation site visit dates and accreditation or recognition status of the Sponsoring Institution or program.

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27.40 Office of the Ombudsperson

The Office of the Ombudsperson functions as an impartial party and offers a safe space to raise concerns about graduate medical education-related issues. Staff members listen, educate, and, when possible, help to locate resources to assist in the resolution of graduate medical education-related issues.

The Office of the Ombudsperson offers an opportunity to report issues about Sponsoring Institutions and programs without impacting their accreditation or recognition status. Allegations presented to this office may or may not rise to the level of non-compliance with ACGME requirements, but they should be within the scope of the ACGME's accreditation or recognition oversight.

If concerned parties have attempted to utilize available local resources without finding a resolution, they may contact the Office of the Ombudsperson. When appropriate, a staff member shall work with the Sponsoring Institution to request an internal inquiry to further explore the issues raised. The Sponsoring Institution shall be asked to collaboratively create an action plan to address graduate medical education-related issues that may be validated through this exploration. The Sponsoring Institution shall then submit a report to the Office of the Ombudsperson detailing the review and the proposed solutions or action plans that may result.

The Office of the Ombudsperson does not render accreditation or recognition decisions or provide information to the ACGME committees. The Office of the Ombudsperson does not conduct formal investigations or make judgements in disputes between individuals and Sponsoring Institutions and/or programs and does not participate in any formal grievance process or offer opinions about institutional or program administrative decisions.

If graduate medical education-related issues cannot be resolved satisfactorily through the Office of the Ombudsperson, reporting parties may raise allegations of non-compliance with ACGME requirements through the Office of Complaints (Policies 27.10-27.30).

If information is shared with the Office of the Ombudsperson that implicates safety, crime, or other matters deemed egregious, the matter may be referred and addressed outside the Office of the Ombudsperson, including, but not limited to, addressing the matter as a formal complaint.

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27.41 Confidentiality of Individuals

The ACGME shall take steps to keep the identity of any reporting party confidential to the extent possible in light of the need to take appropriate action, when a party specifically waives the right to confidentiality, or as required by law. The Office of the Ombudsperson may request permission to identify the individual(s) to the Sponsoring Institution and/or program in order to advocate for fair process and to identify options and strategies for resolution about the actions taken in response to a report, and also to contact the individual(s) if additional information is needed.

27.42 Confidentiality of Sponsoring Institutions' and Programs' Responses to the Office of the Ombudsperson

The ACGME shall maintain the confidentiality of a Sponsoring Institution's and/or program's response(s) submitted to the Office of the Ombudsperson, unless required by law.

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27.50 Submission of Reports to the Office of the Ombudsperson

Before contacting the Office of the Ombudsperson, parties should attempt to resolve issues by utilizing all resources available in the Sponsoring Institution and program unless there is a valid reason for not doing so.

Parties wishing to report graduate medical education-related issues may call the Office of the Ombudsperson if they have questions or wish to first discuss the issues or process before filing a report. Requests for the Office of the Ombudsperson to initiate an internal inquiry with a Sponsoring Institution, however, should be submitted by email .

The Office of the Ombudsperson must have a way to communicate with those who submit reports. Anonymous emails are accepted, but the ability to respond and create a dialogue is essential.

Emailed reports should include the following:

a. a brief summary of the issues, including steps taken to attempt a resolution - if relevant;

b. name, city, and state of the Sponsoring Institution or program; and,

c. contact information for the reporting party.

Reports of alleged issues that occurred only prior to the current and preceding academic year may not be considered. Exceptions shall be considered on a case-by-case basis.

27.60 Office of the Ombudsperson Action for Addressing Reports of Graduate Medical Education-Related Issues

Office of the Ombudsperson personnel shall have initial discussions with parties who contact the office (by phone or email) to inform them about the mechanisms available for reporting issues (including the use of the formal Complaints process). When the concerned parties have confirmed they wish to work through the Office of the Ombudsperson, discussions can continue and official reports can be submitted. Office of the Ombudsperson personnel listen, provide education about options and available resources to assist in the resolution of graduate medical education-related issues, and, when appropriate, request internal inquiries of the Sponsoring Institution to further explore and resolve issues.

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28.00 Advancing Innovation in Residency Education (AIRE)

The implementation of the accreditation process offers an opportunity to help catalyze, acknowledge, and highlight innovation in graduate medical education. While the current Program Requirements provide substantial flexibility to test new educational and assessment approaches, the ACGME anticipates the potential need to offer waivers from compliance with selected requirements to further foster innovation in graduate medical education. Additional discussion of AIRE is maintained on the website.

28.10 AIRE Goals and Objectives

The overarching goal of AIRE is to catalyze greater innovation in residency and fellowship education programs that improves the quality and safety of health care delivered by graduates of those programs. To help achieve this goal the ACGME has a program process to review and approve proposal for pilot programs with the aims of:

a. enabling the exploration of novel approaches and pathways in graduate medical education;

b. enhancing the attainment of educational and clinical outcomes through innovative structure and processes in resident and fellowship education; and,

c. encouraging the incorporation of the following key principles and characteristics of competency-based medical education (CBME) and outcomes into resident and fellow education.

28.20 AIRE Principles and Characteristics

a. Principles

1. Competencies are role-derived, specified in behavioral terms and made public.

2. Assessment criteria are competency-based and specify what constitutes a master-level of achievement.

3. Assessment requires performance as the prime evidence but also takes knowledge into account.

4. Individual learners' progress is dependent on demonstrated competence.

5. The instructional program facilitates development and evaluation of the specific competencies.

28.00 Advancing Innovation in Residency Education (AIRE)

28.20 AIRE Principles and Characteristics

b. AIRE Characteristics

1. Learning is individual;
2. Feedback to the learner is critical;
3. Emphasis is more on the exit criteria than on the admission criteria;
4. Competency-based medical education requires a systematic program (approach);
5. Training is modularized; and,
6. Both the learner and the program have accountability.

28.30 Review Committee Approval Program Requirement Waivers

Applications for AIRE pilots must include:

a. The duration of the approval will depend on the nature of the innovation, and submitting programs applications should clearly specify the rationale for the requested duration.

b. The method of monitoring (e.g., progress reports, updates) will be determined by the Research Unit staff at the ACGME in collaboration with the Review Committee. At and at a minimum, monitoring must include yearly program updates and performance by the residents or fellows on the Milestones.

c. Supporting evidence from the program of assessment developed to support the innovative pathway must be specified provided in the proposal.

Research has demonstrated that effectively performed group process leads to better judgments and decisions. ACGME recommends that proposals should include robust and innovative approaches to group decision making as part of the proposal.

The Review Committee Executive Director will provide official notification to the program director and designated institutional official of the Review Committee's decision.

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28.40 Use of Milestones in the Innovation Pilots

While the use of the ACGME Milestones in AIRE pilots is required as a component of the pilot proposal, the current version of the Milestones has not been sufficiently studied to support using the Milestones as the sole mechanism regarding decisions around resident/fellow progression in an educational program.

28.50 Submission of Proposals

Proposals must be submitted to the ACGME Department of Research, Milestone Development, and Evaluation. All required information must be provided and complete before the proposal shall be considered. AIRE information, including forms for submitting proposals, can be found on the ACGME website.

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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.

ACGME-approved New Requirements: February 7, 2022; effective February 7, 2022

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)

***

***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.

ECFMG™

A Division of Intealth

ECFMG® CERTIFICATION 2025 INFORMATION BOOKLET

Intealth™

Advancing the Global Health Workforce

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.

Stay Up to Date

- Monitor the ECFMG website for any changes to the information in this booklet.
- Subscribe to *The ECFMG Reporter* e-newsletter.
- Follow us on social.

August 21, 2024

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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. ECFMG is a division of Intealth™. 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 2025 ***Information Booklet*** pertains to eligibility periods in 2025. If your eligibility period extends into 2026 and you test in 2026, you must become familiar with and will be subject to the policies and procedures detailed in the 2026 ***Information Booklet***. The 2026 ***Information Booklet*** is expected to be available in August 2025. 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 2025 ECFMG ***Information Booklet*** and 2025 USMLE ***Bulletin of Information*** is subject to change. If changes occur, information will be posted on the ECFMG and USMLE websites. **You are responsible for checking the ECFMG and USMLE websites for updates and changes in policies and procedures.**

We provide important updates on ECFMG Certification and entry into graduate medical education in the United States in ***The ECFMG® Reporter*** newsletter and on Instagram. We encourage applicants to subscribe to ***The ECFMG® Reporter*** and to follow Intealth on Instagram.

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

We strive 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, we 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.

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Introduction

Important Notices

This ***Information Booklet*** reflects information available and requirements in place at the time of publication (August 21, 2024). International medical graduates pursuing ECFMG Certification should monitor the ECFMG and USMLE websites for the most current information.

Launch of MyIntealth™

We are in the process of launching MyIntealth, a new on-line environment that will provide access to our on-line services. MyIntealth will offer users many benefits, including a single user account and common user experience for all ECFMG services.

MyIntealth will replace most of ECFMG's current on-line services, including but not limited to:

- Interactive Web Applications (IWA)
- On-line Applicant Status and Information System (OASIS)
- ECFMG Credentials Upload Tool

The launch of MyIntealth also will change the way that applicants access other ECFMG on-line services, such as those related to the Pathways, and will eliminate many forms for applicants pursuing ECFMG Certification and U.S. graduate medical education.

The launch of MyIntealth will result in significant changes to policies and procedures described in this booklet. **Applicants who plan to use ECFMG services in late 2024 and early 2025 should monitor the ECFMG website for updates and instructions on how to prepare.**

Impact of Change to Accreditation Body for Medical Schools in Canada Effective in July 2025

Currently, medical education programs in Canada leading to the MD degree are accredited by both the Liaison Committee on Medical Education (LCME) and the Committee on Accreditation of Canadian Medical Schools (CACMS). Effective July 1, 2025, CACMS will become the sole accrediting body for medical education programs in Canada.

Accreditation by LCME establishes eligibility to take the United States Medical Licensing Examination® (USMLE®) and to enter U.S. residency programs accredited by the Accreditation Council for Graduate

Medical Education (ACGME). In the absence of LCME accreditation for Canadian medical education programs, Canadian medical school graduates will establish their eligibility for USMLE and ACGME-accredited residency programs through ECFMG Certification.

This means that individuals who graduate from Canadian medical schools on or after July 1, 2025 will be considered international medical graduates for the purpose of entry into graduate medical education (GME) programs in the United States, and, in order for these graduates to enter ACGME-accredited residency programs, the ACGME will require that they either obtain ECFMG Certification or hold a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which the ACGME-accredited program is located.

ECFMG Certification is the standard for evaluating the qualifications of international medical graduates entering the U.S. health care system and includes requirements for medical schools, examination requirements (which include USMLE Step 1 and Step 2 Clinical Knowledge among other requirements), and verification of medical education credentials directly with the issuing institution. For more detailed information, please visit our ECFMG Certification Overview.

Individuals who will graduate from Canadian medical schools on or after July 1, 2025, will be able to apply for ECFMG Certification beginning in late spring 2025, prior to the start of the 2026 residency application cycle in the United States. Additional details and a definitive date when these individuals can begin applying for ECFMG Certification will be provided in a future update. In the interim, these individuals should continue to apply for USMLE exams as planned and based on current policies and procedures.

Individuals who will graduate from medical schools in Canada on or after July 1, 2025, and who plan to pursue U.S. GME should monitor the ECFMG and USMLE websites for detailed information on applying for ECFMG Certification and USMLE.

Introduction

Guide to On-line Services and Forms

Important Note: We are in the process of launching MyIntealth, a new on-line environment that will provide access to our on-line services. MyIntealth will offer users many benefits, including a single user account and common user experience for all ECFMG services.

MyIntealth will replace most of ECFMG's current on-line services, including but not limited to:

- Interactive Web Applications (IWA)
- On-line Applicant Status and Information System (OASIS)
- ECFMG Credentials Upload Tool

The launch of MyIntealth also will change the way that applicants access other ECFMG on-line services, such as those related to the Pathways, and will eliminate many forms for applicants pursuing ECFMG Certification and U.S. graduate medical education.

The launch of MyIntealth will result in significant changes to policies and procedures described in this booklet. **Applicants should continue to monitor the ECFMG website for updates and instructions on how to prepare for the transition to MyIntealth.**

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 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 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, you may submit paper copies.

Mailing Address:
Intealth
ECFMG Certification Program
3624 Market Street, 1st Floor
Philadelphia, PA 19104, USA

We 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

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.

> **Important Note:** Individuals who will graduate from Canadian medical schools on or after July 1, 2025 will be considered international medical graduates for the purpose of entry into graduate medical education programs in the United States, and, in order for these graduates to enter ACGME-accredited residency programs, the ACGME will require that they either obtain ECFMG Certification or hold a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which the ACGME-accredited program is located. Please refer to the ***Important Notices*** section of this booklet for more information.

* 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. For information on the ECFMG Sponsor Note, see Information on Sponsor Notes in the ***World Directory of Medical Schools*** on the ECFMG website.

> **Important Note:** Implementation of the Recognized Accreditation Policy will begin in late 2024. Once the policy is in effect, it will not impact an individual's eligibility for certification. IMGs will still be able to apply for and obtain ECFMG Certification, regardless of whether their medical school meets the current requirements of the Recognized Accreditation Policy. Any updates or changes to the policy will be communicated well in advance. For more information on this policy, visit www.intealth.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. 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*** with an ECFMG note stating it meets ECFMG eligibility requirements. See ***Medical School Requirements*** above and the ***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:

- Have satisfied the requirements of an ECFMG Pathway, which includes attaining a satisfactory score on the Occupational English Test (OET) Medicine, that is valid for ECFMG Certification, **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 FedEx.

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 meet the clinical skills requirement and the communication skills requirement for ECFMG Certification through a Pathway, your ECFMG Certificate is subject to expiration. Your certificate will expire when your Pathway expires, unless you meet the requirements to have your certificate made valid indefinitely (i.e., no longer subject to expiration). For information on obtaining permanent validation of the ECFMG Certificate, refer to the Pathways in the ECFMG Certification section of the ECFMG website.

For detailed information on expiration of the ECFMG Certificate, and information on revalidating a Pathway to revalidate your 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)*** section of this booklet.
- If the name on your **scheduling permit** has been misspelled, contact ECFMG immediately. Use the contact information for General Inquiries on the Contact Us 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.

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 Intealth 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.**

- **Submitting falsified Mini-CEX documentation 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 fraudulent Mini-Clinical Evaluation Exercises (Mini-CEX) as part of an Application for Pathways for ECFMG Certification.

  Following review, the ECFMG Medical Education Credentials Committee determined that 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.**

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 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 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:

- Have satisfied the requirements of an ECFMG Pathway, which includes attaining a satisfactory score on the Occupational English Test (OET) Medicine, that is valid for ECFMG Certification, **OR**
- Have a passing performance on the former Step 2 Clinical Skills (CS) component of USMLE that is valid for ECFMG Certification.

Important Note on Validity of Pathways: The Pathways are offered on a seasonal application cycle, and international medical graduates should consider the timing of their applications carefully. If you meet the clinical skills requirement and communication skills requirement for ECFMG Certification through the Pathways, your accepted Pathway is subject to expiration. The expiration date is based on the Pathways season for which the Pathways application was accepted. An accepted, unexpired Pathway is required to become ECFMG Certified. An accepted, unexpired Pathway also is required to participate in the National Resident Matching Program® (NRMP®) Main Residency Match® (The Match®). For detailed information on the Pathways, including expiration dates for each Pathways season, refer to the ECFMG Certification section of the ECFMG website.

International medical graduates 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).

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 meet the other examination requirements 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:** Accepted Pathways are subject to this seven-year requirement. This means that your Pathways application must be accepted within the seven-year period in order to meet the clinical skills requirement and communication skills requirement for ECFMG Certification.

> Once you satisfy all exam requirements for ECFMG Certification within a seven-year period, you have met the time limit for completing examination requirements. However, accepted Pathways are subject to expiration for other purposes, including for becoming ECFMG Certified and for entering the NRMP Match. If you have satisfied all examination requirements within a seven-year period but need to revalidate a Pathway for other purposes, the revalidation can occur outside of the seven-year period. For detailed information on Pathways expiration and revalidation, refer to the ECFMG Certification section of the ECFMG website.

If you do not satisfy all examination requirements within a maximum of seven years, your earliest 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, 2018 and Step 2 CS on February 20, 2020. He has through January 20, 2025 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, 2025, his passing performance on Step 1 would no longer be valid for ECFMG Certification.

> An international medical graduate passed Step 1 on November 30, 2017 and Step 2 CK on February 1, 2021. She has through November 30, 2024 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, 2024, her passing performance on Step 1 will no longer be valid for ECFMG Certification.

An international medical graduate passed Step 1 on January 15, 2018, and her 2021 Pathways application was accepted on February 1, 2021. Her Pathway will expire on December 31, 2024 (the expiration date for all 2021 Pathways). If she passes Step 2 CK on November 1, 2024, she will have met ECFMG's time limit for completing the exam requirements. However, her Pathway is still subject to expiration for other purposes, including for becoming ECFMG Certified and for entering the NRMP Match. Since the applicant met ECFMG's time limit for completing the exam requirements, revalidation of a Pathway for these purposes can occur outside of the seven-year period.

Under this ECFMG requirement, more than one passing performance can become invalid for ECFMG Certification.

Examples: An international medical graduate passed Step 1 on April 1, 2017, and passed Step 2 CK on May 1, 2018. She had through April 1, 2024 (seven years from her Step 1 passing performance) to complete a Pathway, satisfying the remaining exam requirements for ECFMG Certification. She did not have an accepted Pathways application by April 1, 2024, 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 CK passing performance on May 1, 2018. She now has through May 1, 2025 (seven years from her Step 2 CK passing performance) to pass Step 1 and complete a Pathway, satisfying the remaining exam requirements for ECFMG Certification. If she does not pass Step 1 and complete a Pathway by May 1, 2025, her passing performance on Step 2 CK will no longer be valid for ECFMG Certification.

An international medical graduate passed Step 1 on January 15, 2018 and her 2021 Pathways application was accepted on February 1, 2021. Her Pathway will expire on December 31, 2024 (the expiration date for all 2021 Pathways). The applicant has until December 31, 2024 to pass Step 2 CK before her Pathway expires. If the applicant does not pass Step 2 CK before this date, she will have until January 15, 2025, to pass Step 2 CK and complete Pathways revalidation. If she does not, her passing performance on Step 1 will no longer be valid for ECFMG Certification.

If you have passed a USMLE 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)*** section of this booklet.

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 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's Applicant Information Services immediately in writing of this change in your status. Use the contact information for General Inquiries on the Contact Us page of the ECFMG website. Such changes in your eligibility status include, but are not limited to, the following:
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> - 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 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's Applicant Information Services immediately in writing of this change in your status. Use the contact information for General Inquiries on the Contact Us 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, including but not limited to, 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, or by exception, 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.

Registration and Test Delivery Entities

Step 1 and Step 2 Clinical Knowledge (CK)

ECFMG 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 scoring 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 scoring 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 as defined by the Americans with Disabilities Act (ADA). If you are an individual with a disability under the ADA and

require test accommodations to access the exam, visit the USMLE website before you apply for information regarding test accommodations, including procedures, guidelines, and documentation requirements.

Requesting Additional Break Time Only

Examinees who require additional break time for medical conditions or for other reasons, may apply for additional break time/standard testing time. See the USMLE ***Bulletin of Information*** for more information.

Pre-approved Items

A list of approved personal items that may be permitted in the secure testing area, subject to inspection by test center staff, is available on the USMLE website. See also 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 to test 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 Us 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 Test 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 Us 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, in rare cases, various 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.

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 exam results that are at or above the passing level, prior to or after release, if the USMLE program has a good faith basis for questioning whether the exam result(s) represent a valid measure of knowledge or competence as assessed by the examination. If there are questions related to the validity of your exam result and your result has not yet been reported, your official score report may be delayed or withheld pending completion of further review and/or investigation. Whether questions relating to the validity of your exam result arise after your result has been reported or before, the USMLE reserves the right to cancel the result if it has a good faith basis for questioning the validity of your result. If your result is being investigated for validity concerns, you will be notified in writing by the USMLE Office of the Secretariat. See ***Score Validity*** in the USMLE ***Bulletin of Information***.

USMLE Transcripts

For information on what is included on an official USMLE transcript and how to request one, please visit the USMLE website.

If you apply to residency programs, you may request electronic transmittal of your USMLE transcript to these programs through the residency application service. For additional information, refer to the Electronic Residency Application Service (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.

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. medical 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, 2023, her second attempt at Step 1 on April 15, 2023, and her third attempt at Step 1 on September 15, 2023. In January 2024, 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, 2023 and six months after her most recent attempt on September 15, 2023 was March 15,

2024. 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 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 USMLE 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. medical 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 Certi cation, 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).
>
> Implementation of the Recognized Accreditation Policy will begin in late 2024. Once the policy is in effect, it will not impact an individual's eligibility for certification. IMGs will still be able to apply for and obtain ECFMG Certification, regardless of whether their medical school meets the current requirements of the Recognized Accreditation Policy. Any updates or changes to the policy will be communicated well in advance. For more information on this policy, visit

International medical graduates must document the completion of all requirements for, and receipt of, the nal medical diploma. ECFMG verifies every international medical graduate's nal medical diploma with the appropriate officials of the medical school that issued the diploma. When ECFMG requests veri cation of your medical diploma from your medical school, ECFMG will request the medical school to provide your nal medical school transcript. Veri cation 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 nal 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, certi cates 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 Us 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. 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.

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*** below.

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

Documents must be submitted to ECFMG in the original language. Any document submitted to ECFMG that is not in English must be accompanied by an official English translation that meets ECFMG's translation requirements. Please see the English Translations page in the Resources section of the ECFMG website for ECFMG's translation requirements, our recommended translation service, and other important information.

Original language documents that are not accompanied by an English translation that meets ECFMG's translation requirements will not be accepted. Likewise, English translations that are not accompanied by the original language document will not be accepted.

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.

Related ECFMG Services

Confirming ECFMG Certification to Third Parties

ECFMG's Certification Verification Service (CVS) provides primary-source con rmation 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 veri cation with ECFMG of a physician's certi cation 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.

Residency Application 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 rst- and second-year (PGY-1 and PGY-2) residency positions.

ECFMG also supports individuals applying to residency programs through other residency application services, including Residency Centralized Application Service (ResidencyCAS) and the Central Application (CentralApp).

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 offered through BridgeUSA, a critical program within the Bureau of Educational and Cultural Affairs (ECA) of the U.S. Department of State.

The U.S. Department of State has designated us as a BridgeUSA sponsor for all exchange visitor (J-1) physicians who participate in clinical training programs. Sponsorship is also available for physicians' eligible dependents. We do not sponsor physicians for other U.S. visa types.

For detailed, up-to-date information on our J-1 visa sponsorship program, visit _____

Match Participation Agreement for Programs

2025 Main Residency Match® and Supplemental Offer and Acceptance Program® (SOAP®)
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1.0 INTRODUCTION TO THE MAIN RESIDENCY MATCH AND SOAP

The Main Residency Match ("the Match") 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 U.S. residency positions with the preferences of residency training program directors.

The Match:

- 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 Match 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.

Programs who are unfilled after the algorithm has been processed may seek to fill unfilled position(s) during the NRMP Match Week Supplemental Offer and Acceptance Program® (SOAP®). SOAP is a process occurring during Match Week wherein positions left unfilled in the Match (i.e., after the matching algorithm has been processed) are offered to SOAP-eligible applicants. During Match Week and until SOAP concludes, all positions offered by unfilled programs and accepted by SOAP-eligible applicants, shall be through the R3 system. Not all unfilled programs are required to participate in SOAP.

Programs are advised to carefully read this Agreement and retain a copy for future reference.

Programs are further advised to educate all program faculty and staff on the requirements and policies of the Agreement and to implement monitoring throughout the recruitment cycle to ensure compliance.

2.0 ELIGIBILITY

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.

3.0 MATCH POSITIONS AND PARTICIPANTS

3.1 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 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 Match and are reserved for physicians with prior graduate medical education. These positions are also known as "Physician Positions".

3.2 Program Leadership and Staff

3.2.1 Institutional Official:

Each institution with programs participating in the Match 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 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.

Institutional officials may appoint an institutional administrator, if desired, to assist in the matching process for the institution.

3.2.2 Program Director

Each program participating in the Match shall designate a qualified program director. The program director shall:

1. Ensure adherence to all policies governing the Match as outlined in this 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 Match Participation Agreement prior to the Quota Change Deadline;

6. Register and attempt to fill all of their positions in the Match or another national matching plan;

7. Agree to select U.S. MD and DO senior students ("sponsored applicants") only through the 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.

3.2.3 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 and enter or change program data with the exception of the program's quota and the

SOAP participation status 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.

3.3 Categories of Applicants

3.3.1 Sponsored Applicant

A "sponsored applicant" is:

1. A student enrolled in a U.S. medical school accredited by the Liaison Committee on Medical Education (“LCME”) or by the American Osteopathic Association (“AOA”) Commission on Osteopathic College Accreditation (“COCA”); or

2. A student who graduated from an LCME or AOA COCA-accredited medical school between June 30 of the calendar year the Match opens and 9:00 pm eastern time on the Rank Order List Certification Deadline in the year of the Match.

3.3.2 Independent Applicant

An “independent applicant” is:

1. An applicant who graduated from a LCME-accredited or AOA COCA-accredited medical school prior to the year of the Match;

2. A student enrolled in, or a graduate of, a medical school accredited by the Committee on Accreditation of Canadian Medical Schools; or

3. A student enrolled in, or a graduate of, a medical school outside the United States and Canada that is not accredited by the LCME, the AOA COCA, or the Committee on Accreditation of Canadian Medical Schools, hereafter referred to as an international medical graduate (IMG).

3.3.3 Couples

“Couples” are:

1. Any two individuals, registered as a couple, participating in the Match, and who agree to pair their rank order lists for the purpose of matching to a ranked pair of programs;

2. Sponsored or independent applicants.

4.0 TERMS AND CONDITIONS FOR PARTICIPATION IN THE MATCH

By clicking on the "I Accept" button on the "Sign Match Agreement" screen of the R3 system, designated program leadership attests to having read this Agreement, and after having done so, agrees to and understands:

1. The program will participate in the Match and may participate in SOAP;

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 residency position;

6. The program must adhere to all rules of communication for the Match and SOAP as outlined in the Match Participation Agreement;

7. The program 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 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 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 absent a waiver or deferral from the NRMP;

9. The binding commitment requires programs to request a waiver 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 program 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.

5.2 Match Fees

Match fees are published annually on the NRMP website. Match fees provide programs access to the R3 system, the ability to participate in the Match and SOAP, and access to certain Match-related lists and reports.

Fees will not be waived for institutions and programs that are activated for Match participation and subsequently withdrawn either by the sponsoring institution, by the program, or by the NRMP.

Each sponsoring institution with programs in the Match pays 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 invoice the institution for those fees and all incurred expenses, which must be paid within thirty (30) days of the invoice date.

All Match fees are non-refundable.

6.0 PARTICIPATION IN THE MAIN RESIDENCY MATCH AND SOAP

The Match 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; 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 Programs is available to review on the NRMP website.

6.2 Interview Period

The recruitment phase for the Main Residency Match must be transparent, grounded in equitable practices, reflect mutual respect for the needs of applicants and programs, and minimize unnecessary pressure. To that end, applicants and programs are bound by the terms of the applicable Match Participation Agreement to demonstrate ethical behavior when engaging in interview offers and acceptances.

During the recruitment phase, programs shall:

1. Extend interview offers that equal, not exceed, the total number of available interview slots;

2. Provide applicants no less than 48 hours to accept or reject an interview invitation; and

3. Apply reasonable measures of notification (e.g., one-to-two weeks' notice) when needing to cancel or reschedule an interview.

During recruitment, programs may expect applicants to make judicious assessment of and decisions about interview offers, accepting only those they intended to fulfill and apply reasonable measures of notification (e.g., one-to-two weeks' notice) when needing to cancel or request rescheduling of an interview.

6.3 Completeness, Timeliness, and Accuracy of Information

6.3.1 Between the Program and Applicants

1. Programs are responsible for ensuring the completeness, timeliness, and accuracy of all information provided to applicants. This includes:

    a. 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

    b. All written, electronic, and verbal information provided to the NRMP.

2. For the Main Residency Match and SOAP, programs must disclose to applicants, at the start of recruitment, the application service or process they will require.

3. The omission of information pertinent to an applicant's decision to rank a program may be deemed a violation of this Agreement. Before the Rank Order List Certification Deadline, or the offering of a position through SOAP, the program shall:

    a. 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;

        i. Once provided, applicants must be notified of any material change to the appointment agreement.

4. Provide all institutional and program policies regarding eligibility for appointment to a residency training position including but not limited to:

    a. Expected or required academic, educational, or prior training credentials;

    b. Pre-employment drug testing and background check;

    c. Information relevant to licensure status or visa status.

Programs shall obtain a signed acknowledgement of such communication from

each applicant interviewed or be able to demonstrate that eligibility requirements were made available to each applicant interviewed in accordance with Section 4.0 of this Agreement. The timely disclosure by the program of the official policies of the appointing institution and/or program does not imply that the applicant interviewed will be ranked, will receive a matched position, or have an offer of a position extended during SOAP.

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 the 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.

6.3.2 Between the Program and the NRMP

Programs have an obligation to submit complete, timely, and accurate information to the NRMP for the period beginning with submission of an electronically signed Match Participation Agreement until the 45th day following the start date of the program's positions processed by the matching algorithm or offered through SOAP, or the conclusion of any NRMP-related waiver or deferral review, violation investigation or appeal process, whichever is later.

6.4 Confidentiality

Program information contained in the R3 system is confidential and available only to authorized users. Unauthorized use or disclosure of such information by a program 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.
    a. Rank order list 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 Rank Order List Certification Deadline and/or the start of SOAP Offer Rounds:

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.

6.5 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, will determine the offering of positions and placement of applicants through the 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.

6.6 Three-Year Medical Education Curriculum

Programs affiliated with medical schools providing a 3-year medical education curriculum must not enter into agreements with students regarding training positions

outside of the Match. Programs must not:

1. Promise or guarantee (verbally or in writing) residency training positions;

2. Offer “conditional acceptance”, “pre-matched,” or “matched” positions outside of the Match;

3. Compel, request, or require that students commit to the training program prior to the release of the Match results;

4. Indicate or imply that a training position is secured or guaranteed before Match results are released; or

5. Prevent applicants from exploring, applying to, interviewing with, or ranking programs of their choice.

7.0 MAIN RESIDENCY MATCH

To participate in the Match, eligible programs must be activated by the institutional official, registered for the Match, and submit a certified rank order list through the R3 system before the Rank Order List Certification Deadline.

7.1 Program Quota, Tracks, and Reversions

7.1.1 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. With respect to quota change requests made before the Quota Change Deadline:

    a. Programs may increase, decrease, or make other changes to the quota before the Quota Change Deadline;

    b. Quota changes must be made in the R3 system; and

    c. Quota changes must be approved by the institutional official.

2. Quota change requests made after the Quota Change Deadline:

    a. Must be in writing to support@nrmp.org and must be approved by the institutional official;

    b. Must demonstrate substantial hardship, such as loss of funding or accreditation, or an increase in the number of program positions approved after the Quota Change Deadline; and

    c. Are subject to the NRMP’s review and approval.

7.1.2 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:

1. Create a separate rank order list for each track; and

2. Place in each track the predetermined track quota; not to 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.

7.1.3 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. Reversions may include tracks created to identify the position(s) created for individuals enrolled in an affiliated 3-year medical education curriculum program.

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.

The NRMP shall regularly monitor the compliance of Match-participating programs in registering and attempting to fill all eligible positions through the Match.

7.2 Withdrawal from The Match

Any registered program that will not offer positions through the Match must withdraw from the Match through the R3 system.

7.2.1 Withdrawal Before the Quota Change Deadline

The institutional official must confirm the program's withdrawal in the R3 system by the Quota Change Deadline.

7.2.2 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 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.

7.2.3 Withdrawal by the NRMP

At any time before Match results are released, the NRMP may withdraw any program for which NRMP believes there is credible evidence that the program has violated the terms of this Agreement. Upon withdrawing a program, the NRMP shall note in the R3 system that the program is the subject of a "pending action" and this designation shall remain until the program has waived or exhausted the opportunity to contest the action pursuant to the Violations Policy.

The NRMP's authority to withdraw a program from the Match under this section is in addition to its authority to impose sanctions for violations of this Agreement. The decision by the NRMP to withdraw a program under this section shall remain in place and shall not be subject to any suspension in the event the institution or program contests the withdrawal or other action by the NRMP under the dispute resolution process set forth in Section 19.

7.3 Submission of Rank Order Lists

To participate in the Match, programs must enter and certify their final rank order list in the R3 system before the 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.

7.3.1 Applicant Eligibility for Ranking

Before certifying the rank order list, programs should:

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;

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; and

3. Ensure each ranked applicant meets requirements for licensure, as published by the programs state Licensure Board.

The NRMP will not create or modify any program's rank order list.

7.3.2 Submitting a Rank Order List

Programs may create 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.

    a. Requests received more than 24 hours after the notification of an uncertified list will not be processed by the NRMP.

    b. Only the rank order lists displayed in the R3 system at the time of the Rank Order List Certification Deadline will be certified.

    c. Once courtesy certification is complete, the NRMP will not uncertify the rank order list.

7.4 Notification of Match Status

At the published time during Match Week, the NRMP will notify all programs who submitted a certified rank order list of their Match status (i.e., if the program's positions filled) via the R3 system and through courtesy email.

Upon the release of Match status, programs are considered:

1. **Filled** if all positions were matched with applicants; or

2. **Unfilled** if all positions were not fully matched with applicants. Unfilled programs may be eligible to participate in SOAP.

Programs must adhere to communication policies as outlined in this Agreement.

7.5 Notification of Match Results

At the published time during Match Week, programs who submitted a certified rank order list will receive notification of their Match results (i.e., which applicants matched into the program) via the R3 system and through courtesy email.

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 Match calendar.

7.6 Communication About Appointments

Violations of any policies pertaining to communication between programs and applicants must be reported to the NRMP at policy@nrmp.org.

7.6.1 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 the Match.

7.6.2 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 SUPPLEMENTAL OFFER AND ACCEPTANCE PROGRAM (SOAP)

The Supplemental Offer and Acceptance Program ("SOAP") provides a uniform system for programs 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 must designate their SOAP status in the R3 system before the Quota Change Deadline. 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.

8.1.1 Programs Electing to Participate in SOAP

Programs with the SOAP status designated as "Yes":

1. Must have unfilled positions remaining after the matching algorithm has been processed;

2. Agree to only consider SOAP-eligible applicants for unfilled positions until the conclusion of SOAP; and

3. 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 received from SOAP-eligible applicants either through the Electronic Residency Application Service ("ERAS") or the application service required by the program;
    a. Policies surrounding application submissions are determined by the application service and not the NRMP.

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.

    a. 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.

8.1.2 Programs Electing Not to Participate in SOAP

Match-participating programs with the SOAP status designated as "No" cannot solicit or consider applications from or extend offers to any applicants until SOAP concludes.

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

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 published 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. Prepare and send applications to their programs of interest;
3. Begin receiving communications from SOAP-participating programs; and
4. Receive offers through the R3 system.
    a. 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.

8.4 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 applicant does not submit any applications to SOAP-participating programs during Match Week;
    a. Applicants who have submitted any applications during Match Week will be ineligible to participate in the SOAP exception.
2. The position sought is not affiliated with a Match or SOAP-participating residency program; or
3. The position does not qualify for training credit in an ACGME-accredited residency program.

8.5 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.

8.6 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 the Match and SOAP, programs:

1. Are in a binding commitment with the applicant and must offer an appointment as matched or offered:

    a. 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 this Agreement.

2. Must begin training applicants on the start date specified in the appointment contract with the intent to complete the applicant's training:

    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 in effect on the Rank Order List Certification Deadline or when the program submits its preference list if the program participates in SOAP.

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, or during SOAP, 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 the 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 the binding Match commitment, or an offer 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 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.

Absent a waiver or deferral from the NRMP, failure to honor this binding commitment will be

considered a violation of this Agreement.

11.0 VACANT POSITIONS

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

Programs are expected to conduct their affairs in an ethical, professional, and responsible manner.

Programs have a right to expect applicants and medical schools to also 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, 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, the NRMP will determine whether to investigate a reported and alleged breach of this Agreement. The types of violations the NRMP may investigate include but are not limited to

1. Failure to provide complete, timely, and accurate information during the application, interview, matching, and SOAP processes;

2. Misrepresentation of 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.

The NRMP's decision whether to investigate an alleged violation is final and not subject to appeal.

12.2 Reporting of Violations

Programs should report to NRMP any known or suspected violation(s) of this Agreement within one year of learning about the suspected violation(s). If the known or suspected violation(s) pertains to a matched applicant, the violation must have occurred no later than the 45th day after the start date of the relevant appointment contract.

12.3 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. Programs 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.

12.4 Withdrawal Due to Suspected Violation

12.4.1 Authority

The NRMP's authority to withdraw an applicant or program 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.

12.4.2 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 applicant has waived or exhausted all avenues of appeal as outlined in the NRMP Violations Policy.

The 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.

12.4.3 Confirmed Violations

If the NRMP's investigation of an alleged violation results in a finding that a program has committed a violation of this Agreement, the program may be withdrawn from the 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 Program Use of Match Information

Programs may use the R3 system and the information contained therein solely for the purpose of their participation in the Match and/or SOAP. 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.

Programs 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 programs and program staff is considered a violation of this Agreement and may result in sanctions to the program.

14.2 NRMP Use of Match Information

Each program 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 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 program;
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 authorized providers or the NRMP.

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, and technology applications and service tools offered by the NRMP.

15.0 REPRESENTATION AND WARRANTIES

Each program represents and warrants to the NRMP that all of the information provided, or that will be provided, by such program to the NRMP is at all times complete, timely, and accurate to the best of such program's knowledge at the time such information was or will be provided.

Each program further represents that its 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 program represents that they have read, understood, and agrees to the NRMP's Privacy Statement.

16.0 DISCLAIMERS

The parties acknowledge that the fees charged by the NRMP for participation in the Match 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 Match 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 Match, the R3 system, or the automated systems and services utilized by the NRMP to implement the Match 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 Match 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, THE MATCH OR SOAP, 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.

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 A PROGRAM, AN APPLICANT, 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 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.

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 Match, this Agreement, or the breach thereof, between or among the NRMP and any applicant or program participating, or seeking participation, in the Match 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 or if one of the parties to the dispute is a state entity and that State's laws mandate that such entity not be compelled to participate in an arbitration proceeding. 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 (or judicial entity, if such a judicial entity is required to be involved for the reasons set forth in the first paragraph of Section 19.0) 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 (or judicial entity, if applicable) 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 (or judicial entity, if applicable) shall have the power to modify any sanctions imposed by the NRMP unless: (1) there is no basis in fact for the NRMP's finding of a violation; or (2) 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) (or judicial entity, if applicable) may construe and interpret, but may not vary or ignore, the terms of this Agreement. The arbitrator(s) (or judicial entity, if applicable) shall not have the power to make an award that is inconsistent with the provisions of this Agreement or with District of Columbia law.

20.0 LIMITATION OF ACTION

Any party who desires to contest a violation decision by an NRMP Review Panel, as outlined in the *Disposition of Match Violation Investigation* (“Disposition”), must notify the NRMP in writing of its intent to do so within 10 business days from that party's receipt of the Disposition. Moreover, any party who wishes to challenge a decision of an NRMP Review Panel or bring a separate cause of action, regardless of form, arising out of or related to the Match, this Agreement, or the breach thereof, or any other dispute between the NRMP and any applicant or program participating, or seeking participation, in the Match, must file a written demand for arbitration within 30 calendar days of receipt of the Disposition or within 30 calendar days of the accrual of the cause of action, 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.

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 Disposition, or if the party does not file a written demand for arbitration within 30 calendar days of receipt of the Disposition, that party is deemed to have waived and is barred from later filing a demand for arbitration or seeking other relief. The obligation to file a written demand for arbitration does not apply to any party that is a state entity and that state’s laws mandate that such entity not be compelled to participate in an arbitration proceeding.

21.0 GENERAL

This Agreement is governed by the laws of the District of Columbia, excluding its choice of laws and 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 Match 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.

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