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**USF HEALTH - Graduate Medical Education**

# Request for New Residency or Fellowship Program

**Return Completed form and attachments in one PDF packet to**: [Submitt.el37cwuc4o6n9uwv@u.box.com](mailto:Submitt.el37cwuc4o6n9uwv@u.box.com)

1. **DEMOGRAPHIC INFORMATION FOR THE PROPOSED PROGRAM**

|  |  |  |
| --- | --- | --- |
| Proposed Program Name: | Click here to enter text. | |
| Department: | Click or tap here to enter text. | |
| Division (if applicable): | Click or tap here to enter text. | |
| Core Program (if applicable): | Click or tap here to enter text. | |
| Program Director Name | Click here to enter text. | |
| Program Administrator Name | Click here to enter text. | |
| Accreditation Available | ACGME  Other Accreditation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Accreditation Exempt | |
| Length of Program in Years | Click here to enter text. | |
| Proposed Funding Source | Hospital(s), Name: Click or tap here to enter text.  Department, Name: Click or tap here to enter text.  Grant, Name: Click or tap here to enter text.  Other (describe):Click or tap here to enter text. | |
| Total Number of Positions | Click here to enter text. | |
| If approved, number of trainees per PGY level in upcoming (\_\_\_\_\_\_\_\_\_\_)  Academic year: | PGY1 | Click here to enter text. |
| PGY2 | Click here to enter text. |
| PGY3 | Click here to enter text. |
| PGY4 | Click here to enter text. |
| PGY5 | Click here to enter text. |
| PGY6 | Click here to enter text. |
| PGY7 | Click here to enter text. |
| PGY8 | Click here to enter text. |
| If approved, number of trainees per PGY level in following (\_\_\_\_\_\_\_\_\_\_\_) Academic year: | PGY1 | Click here to enter text. |
| PGY2 | Click here to enter text. |
| PGY3 | Click here to enter text. |
| PGY4 | Click here to enter text. |
| PGY5 | Click here to enter text. |
| PGY6 | Click here to enter text. |
| PGY7 | Click here to enter text. |
| PGY8 | Click here to enter text. |
| If approved, number of trainees per PGY level in following (\_\_\_\_\_\_\_\_\_\_\_) Academic year: | PGY1 | Click here to enter text. |
| PGY2 | Click here to enter text. |
| PGY3 | Click here to enter text. |
| PGY4 | Click here to enter text. |
| PGY5 | Click here to enter text. |
| PGY6 | Click here to enter text. |
| PGY7 | Click here to enter text. |
| PGY8 | Click here to enter text. |

1. **RECRUITMENT INFORMATION**

|  |  |
| --- | --- |
| Number of Competing Programs in the Country | Click here to enter text. |
| Number of Competing Programs in the State | Click here to enter text. |
| Program Locations *(e.g., UF Gainesville, University of Miami)* | |
| Click here to enter text. | |
| Estimated Number of Applicants to All Programs During Last Recruitment Cycle (if available) | Click here to enter text. |

1. **EDUCATIONAL PROGRAM INFORMATION**

|  |
| --- |
| Provide a rationale for this new program. The rationale must be educational in nature and not based on service demands. E.g., how would the new program enhance the learning environment, improve the experience on certain rotations, complement existing programs, and further enhance the mission of the institution/university? |
| Click here to enter text. |
| What other trainees would rotate through this program (i.e., medical students, fellows from other programs, residents, international scholars)? What impact, if any, would this program have on these trainees? |
| Click here to enter text. |
| What impact, if any, would there be if this new program was not approved? |
| Click here to enter text. |

1. **PROGRAM RESOURCES**

|  |  |
| --- | --- |
| **Program Director** percent protected FTE of non-clinical time for administration of the program | Click or tap here to enter text. |
| **Program Administrator** percent protected FTE for administration of the program | Click or tap here to enter text. |
| Number of Core Faculty expected to participate in the program (Program Description will contain the list of names and clinical interests) | Click here to enter text. |
| Core Faculty to Trainee Ratio, if program is approved: | Click here to enter text. |
| Number of non-Core Faculty expected to participate in the program | Click here to enter text. |
| Describe the facilities and resources available to residents including faculty to resident ratio, availability and diversity of patient population, library facilities, on-call rooms, laboratories, offices, computers, etc. | |
| Click here to enter text. | |
| What impact would the addition of this program have on space and facilities, such as office space, computers, call space? Does the current research infrastructure (lab space, faculty expertise, research funding) support the addition of this program? Please provide details. | |
| Click here to enter text. | |

1. **STRATEGIC IMPACT**

|  |
| --- |
| How does the addition of this program affect residents, faculty, GME, university, and hospitals? |
| Click here to enter text. |
| Is there a need for physicians in this specialty locally? Regionally? Statewide? Nationwide? Please explain. |
| Click here to enter text. |

1. **ATTACHMENTS & APPROVALS**

*(note for ACGME programs documents will go under more scrutiny after GMEC submission)*

|  |  |
| --- | --- |
| * Provide a Program Description which should include:   + Program Overview   + Mission and aims of the program   + Educational Outcomes   + Description of training locations (what institutions will be involved? What resources exist for the training of the residents/fellows? Do affiliation agreements already exist?)   + Curriculum, including, expected rotation schedule and call schedule, by PGY level.   + Requirements of the trainees in the program (E.g., participation in the education program, clinical care of patients, presentation at a national meeting, publication of 1 academic paper)   + Description of evaluations of the trainees and the program   + Pre-requisites for admission (non-accredited programs ONLY) |  |
| * Faculty roster with Board certification status and specialty |  |
| * Provide the competency-based goals and objectives for each rotation.   See [*Goals and Objectives Template*](https://usf.box.com/s/nwmt4wbaj5o7984ww14o8d4jxmgez2qb) |  |
| * Scope of Practice by PGY Level   See[*Scope of Practice Template*](https://usf.box.com/s/v5klgh1sorr14zcbibqjaxnmgwg6khja) |  |
| * Block Schedule   See[*Block Diagram FAQ*](https://usf.box.com/s/ri08l7ldq0uxzoh3tk36rokzhv040a7l) *and* [*Template*](https://usf.box.com/s/tpmz2u8xs7ocromkudikchpddu8d6gbw) |  |
| * Complete Program Director Form   See New PD Form ([ACGME](https://usf.box.com/s/eygb7vl9wl6jw0ee58xxu9kh6ayg0b3k) or [Non-ACGME](https://usf.box.com/s/b5ge4hknqjnlc39yeb5knks2n2x9fmfm)) |  |

**GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC) APPROVAL**

|  |  |
| --- | --- |
| Date to be presented at the GMEC | Click or tap to enter a date. |
| Who will be presenting this request at the GMEC? | Click or tap here to enter text. |
| Contact Cherie Dilley to schedule a meeting to discuss the business/logistics side of the program setup.  *Note: GME and program meeting needs to be scheduled after ACGME approval.* | Meeting Date  Click or tap to enter a date. |

***NOTE:  If for an Unaccredited Fellowship Program, Signature must be obtained from BOTH the Fellowship Director AND the Program Director for the specialty.***

Signature   Date

|  |  |  |
| --- | --- | --- |
| **Fellowship Director’s Signature** |  |  |
| **Program Director’s Signature** |  |  |

*By signing this form the department agrees to provide resources to support the program including, but not limited to, Program Director and Program administrator protected time as required by the ACGME.*

|  |  |  |
| --- | --- | --- |
| **Department Chair’s Signature** |  |  |

**Completed forms should be returned to**: [*Submitt.el37cwuc4o6n9uwv@u.box.com*](mailto:Submitt.el37cwuc4o6n9uwv@u.box.com)

*GME Internal Use ONLY*

**AFFILIATED HOSPITAL/FUNDING SOURCE APPROVAL:**

Affiliated Hospital / Funding Source \_\_\_\_\_\_\_\_\_\_\_

Chief Medical Officer Approved Date approved: \_\_\_\_\_\_\_\_

Approved by GMEC: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Program Opened in WebADS (as applicable): Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by ACGME RRC (as applicable): Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Rev September 2021*