

**USF HEALTH - Graduate Medical Education**

# Request for Resident / Fellow Complement Change

1. **DEMOGRAPHIC INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Program Name | |  | Click here to enter text. | | | |
| Program Director | |  | Click here to enter text. | | | |
| Accreditation | |  | ACGME  Other Accreditation  Accreditation Exempt | | | |
| Length of Program in Years | | | |  | | |
| Type of Request  *(i.e., Permanent Increase/decrease or Temporary increase)* | | | |  | | |
| Proposed Funding Source | | | |  | | |
| **CURRENT** Number of Trainees in Program by PGY Level | | | | **REQUESTED** number of Trainees by PGY Level | | |
| PGY-1 |  | | | PGY-1 | |  |
| PGY-2 |  | | | PGY-2 | |  |
| PGY-3 |  | | | PGY-3 | |  |
| PGY-4 |  | | | PGY-4 | |  |
| PGY-5 |  | | | PGY-5 | |  |
| PGY-6 |  | | | PGY-6 | |  |
| PGY-7 |  | | | PGY-7 | |  |
| PGY-8 |  | | | PGY-8 | |  |
| TOTAL Number of Trainees in Program Last Year | | | | | Click here to enter text. | |
| TOTAL Number of Trainees in Program Two Years Prior | | | | | Click here to enter text. | |

1. **EDUCATIONAL PROGRAM INFORMATION**

|  |  |
| --- | --- |
| **Provide a rationale for this change**. The rationale must be educational in nature and not based on service demands. E.g., increased time for didactics, enhance the learning environment, improve the experience on certain rotations, new clinical experiences required by the accrediting agency, improved compliance with duty hour requirements, increased elective time. | |
| Click here to enter text. | |
| What other trainees rotate through this program (i.e., medical students, fellows from other programs, residents, international scholars)? What impact, if any, would this change have on these trainees? | |
| Click here to enter text. | |
| What impact, if any, would there be if this change was not approved? | |
| Click here to enter text. | |
| Have there been any changes in complement in the past three years? If so, please describe. | |
| Click here to enter text. | |
| Current Core Faculty to Trainee Ratio | Click here to enter text. |
| Proposed Core Faculty to Trainee Ratio, if change is approved | Click here to enter text. |
| What impact would this change have on space and facilities, such as office space, computers, call space? | |
| Click here to enter text. | |
| Do current clinical volumes support this change? Please provide data. | |
| Click here to enter text. | |
| Does the current research infrastructure (lab space, faculty expertise, research funding) support this change? Please provide details. | |
| Click here to enter text. | |

1. **RECRUITMENT DATA FROM LAST RECRUITMENT CYCLE**

**\*\*Note:** Only complete this section if the complement increase is longer than 2 months.\*\*

|  |  |
| --- | --- |
| Number of Open Positions | Click here to enter text. |
| Number of Applications Received | Click here to enter text. |
| What is your program’s history of filling with qualified applicants? | Click here to enter text. |

1. **STRATEGIC IMPACT**

**\*\*Note:** Only complete this section if the complement increase is longer than 2 months.\*\*

|  |
| --- |
| How will the complement change affect the following: |
| 1. Current Residents and/or Fellows? |
| Click here to enter text. |
| 1. Faculty? |
| Click here to enter text. |
| 1. Program? |
| Click here to enter text. |
| 1. Community? |
| Click here to enter text. |

1. **IMPLEMENTATION PLAN / TIMING**

**\*\*Note:** Only complete this section if the complement increase is longer than 2 months.\*\*

**(Include projected start date, and PGY levels)**

***(Example: If complement request of three residents is approved, one PGY-1 resident to begin on July 1, 2016, and an additional resident added each subsequent year)***

|  |
| --- |
| Click here to enter text. |

1. **ATTACHMENTS & APPROVALS**

**\*\*Note:** Attachments required if the complement increase is longer than 2 months.\*\*

|  |  |
| --- | --- |
| Program Description attached |  |
| Block Schedule attached |  |
| Most recent accreditation letter attached, including corrective actions for any citations | n/a |

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

**Completed forms should be returned to**:

Cuc Mai, MD

Sr. Associate Dean, Graduate Medical Education/DIO

17 Davis Blvd., Suite 315

Tampa, FL 33606

(*or via e-mail to* [*Submitt.el37cwuc4o6n9uwv@u.box.com*](mailto:Submitt.el37cwuc4o6n9uwv@u.box.com))

**The GME Office will ensure completion of the section below...**

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**AFFILIATED HOSPITAL/FUNDING SOURCE APPROVAL:**

Chief Medical Officer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Additional Funding Source – if required)*

Chief Medical Officer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Approved by GMEC (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Rev Mar 2022*