#

**USF HEALTH - Graduate Medical Education**

# REQUEST FOR CHANGE IN PROGRAM DIRECTOR

**BASIC INFORMATION**

|  |  |
| --- | --- |
| Program Name: | Click here to enter text. |
| CURRENT Program Director: | Click here to enter text. |
| Will the current Program Director remain in the program as teaching faculty? | [ ]  Yes [ ]  No |
| Program Accreditation: | [ ]  ACGME [ ]  Other Accreditation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Accreditation Exempt |
| PROPOSED Program Director: | Click here to enter text. |
| E-mail: | Click here to enter text. |
| Phone Number: | Click here to enter text. |
| Start Date for Proposed Program Director: | Click here to enter text. |
| Appointment is (check one): | [ ]  Interim [ ]  Permanent |
| *Note: Proposed Program Director should continue in his/her position for a length of time adequate to maintain leadership continuity and program stability.* |
| Date Proposed Program Director first appointed as faculty member in the department: | Click here to enter text. |

**PERSONAL STATEMENT / QUALIFICATIONS**

|  |
| --- |
| Please describe how your experience makes you well suited for a role as Program Director. Summarize your qualifications, including prior experience as a Program Director, other educational leadership positions held, attendance at any ACGME meetings, involvement in a training program, etc. |
| Click here to enter text. |
| As applicable, do you meet the ACGME and/or program specific RRC requirements for Program Director? | [ ]  Yes [ ]  No |

 **EDUCATION & TRAINING**

|  |  |  |  |
| --- | --- | --- | --- |
| Institution and Location | Degree | MM/YY | Field of Study |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**PUBLICATIONS**

(Please limit to no more than 10 peer-reviewed publications and/or manuscripts)

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

**ATTACHMENTS**

|  |  |
| --- | --- |
| * Current CV of proposed Program Director
 | [ ]   |

 Signature   Date

|  |  |  |  |
| --- | --- | --- | --- |
| **CURRENT Program Director’s Signature**  |   |  |  |
| **PROPOSED 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 ddshorter@health.usf.edu*)

**GME DOCUMENTATION / PROCESS**

|  |  |
| --- | --- |
| * Proposed Program Director is ABMS certified (Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
 | [ ]  |

|  |  |
| --- | --- |
| * Current Florida License verified
 | [ ]  |

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

Entered into WebADS (as applicable): Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Rev Jan 2018*