

**Graduate Medical Education**

**Request for Resident/Fellow**

**Complement/FTE Change**

1. **REQUEST OVERVIEW**

|  |  |
| --- | --- |
| Type of Request/Approvals Needed | Increase  Decrease |
| Permanent  Temporary  If the request is temporary, what is the duration? Click here to enter text. |
| *Check all that apply:*  Affiliate Funding Approval  Department Funding Approval  GMEC and/or ACGME Approval  Department Funding Approval for Additional PD/PA requirements\*  *\*If box is checked, program required to include a letter of support from the chair.* |

1. **PROGRAM INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Program Name | |  | Click here to enter text. | | | |
| Program Director | |  | Click here to enter text. | | | |
| Accreditation | |  | ACGME  Other Accreditation  Accreditation Exempt | | | |
| Citations/AFIs | |  | Citations  AFIs  Please explain: Click here to enter text. | | | |
| Length of Program in Years | | | | Click here to enter text. | | |
| Type of Request  *Check all that apply* | | | Permanent Complement Increase  Temp Complement Increase  Permanent Funding Increase  Temp Funding Increase  Complement Decrease  If the request is temporary, what is the duration? Click here to enter text. | | | |
| Proposed Funding Source (additional information required in Section IV) | | | | Click here to enter text. | | |
| Total number of new FTEs requested | | | | Click here to enter text. | | |
| **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. **LEARNING ENVIRONMENT 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. | |
| Do trainees in this program rotate with other programs/departments and do those programs/departments agree to accommodate the request? | |
| 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 at USF and/or the affiliate site? | |
| Click here to enter text. | |
| Do current clinical volumes support this change? Please provide data (e.g case logs and/or patient census data) and ACGME and Board requirements. | |
| 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 for permanent increase requests.\*\*

|  |  |
| --- | --- |
| 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 AND FINANCIAL IMPACT**

**\*\*Note:** Only complete this section for permanent increase requests.\*\*

|  |
| --- |
| Please address the overall strategic impact of the increase by addressing the impact on current trainees, faculty, the program, the affiliates, and the community |
| 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. |
| Please provide information on program graduates staying at USF, affiliate sites, or the State of Florida to practice in their specialty |
| Click here to enter text. |
| Current breakdown of FTEs for program across affiliates |
| Click here to enter text. |
| Proposed breakdown of FTEs for program across affiliates |
| Click here to enter text. |
| Does the program have unused FTEs at an affiliate site? If yes, please explain why those do not meet the needs of the program if additional FTEs are being requested from another affiliate. |
| Click here to enter text. |
| Please provide a rationale for how FTE request aligns with affiliate strategic initiatives and service line needs. How will the change in FTE impact clinical workflows at the affiliate site? |
| Click here to enter text. |
| Does a service line support the FTE request? Please provide details |
| Click here to enter text. |
| Can the clinical need be handled by other levels of providers/staff (APP, RN, other personnel)? Please explain |
| Click here to enter text. |
| Will the FTE increase lead to an increase in PD, APD, or PA ACGME-required protected time for administration of the program? If so, please provide details. Please provide information on the department’s ability to support the growth of the program. | |
| Click here to enter text. | |
| Does this increase the FTE requirement for Core Faculty? If so, please provide details. Does the department agree to financially support this requirement? | |
| Click here to enter text. | |
| Do you anticipate any additional costs beyond trainee salary and benefits for the proposed increase? |
| Click here to enter text. |

1. **IMPLEMENTATION PLAN / TIMING**

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

**(Include projected start date, comment on FTE changes to program leadership, and PGY levels)**

***(Example: If 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 increase is longer than 2 months.\*\*

|  |  |
| --- | --- |
| Program Description, Mission, and Aims attached |  |
| Block Schedule attached (current and highlight proposed changes) |  |
| Most recent accreditation letter attached, including corrective actions for any citations | N/A |
| ACGME Case Log Program Minimums Report | N/A |
| Program Accreditation Dashboard | N/A |
| Provide proposed new rotations at the affiliate if applicable and the Goals and Objectives for those rotations | N/A |
| Promissory letter from department for back up funding for the total number of years needed if affiliate funding has not been approved | 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** |  |  |
|  | | |
| ***\*\*By signing below, if the funding is not approved, the program agrees to not fill the position or the department agrees to take full financial responsibility for the unfunded position(s). Furthermore, the department will provide the resources mandated by ACGME to support the complement size for the program.*** | | |
| **Department Chair’s Signature** |  |  |

**Completed forms should be returned to**:

Cuc Mai, MD

Sr. Associate Dean, Graduate Medical Education/DIO

(*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...**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

|  |  |  |  |
| --- | --- | --- | --- |
| Current cost of stipend, benefits, and malpractice (all-in cost) | | | |
| Per FTE: |  | Total for request per year: |  |
| PGY level used in calculation | |  | |
|  | | | |
| Approved by Affiliate? | |  | |

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

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

*Rev Dec 2023*