

## Initial Request to Establish a New Program

**Instructions:** This one-page form and accompanying application must be completed for any ACGME or non-ACGME accredited programs applying for initial approval of the GMEC.

Requesting Department: \_\_\_\_\_

Name of Program: \_\_\_\_\_

Duration of Program: \_\_\_\_\_

Proposed # of trainees per year of training: \_\_\_\_\_

If applicable, current # of residents in the program per year of training: \_\_\_\_\_

PGY starting level:  PGY1  PGY2  PGY3  PGY4  PGY5  PGY6  
 PGY7  PGY8 and above

Proposed Start Date: \_\_\_\_\_

Indicate funding source (Click as appropriate):

Hospital, Name: \_\_\_\_\_  Department: \_\_\_\_\_

Grant: PI's Name: \_\_\_\_\_  Other (describe) \_\_\_\_\_

Please attach copy of letter(s) or notice of awards that verify funding source and its duration.

Will resident stipends differ from HMH-established stipends for each PGY level?  No  Yes  
(If the answer is yes, include an explanation):

Does this program have any graduates? Yes  No

Will this program be accredited by any accrediting body? Yes  , accrediting body? \_\_\_\_\_ No

Are there any program requirements for this program? Yes  No

If yes, please attach program requirements.

Total number of faculty available for teaching in this program: \_\_\_\_\_

Submitted by (proposed program director):

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

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Approved by:

Name of Department Chair: \_\_\_\_\_

Signature of Department Chair: \_\_\_\_\_

If fellowship:

Name and signature of Division Chief: \_\_\_\_\_

Name and signature of Core Program Director : \_\_\_\_\_

**APPLICATION AND INTERNAL REVIEW FORM FOR  
NON-ACGME ACCREDITED PROGRAMS**

**Instructions:** Complete this application form for review and approval of non-ACGME-accredited programs.

**A. ACCREDITATION INFORMATION**

If your program is affiliated with a core ACGME program sponsored by Methodist, provide the following information.

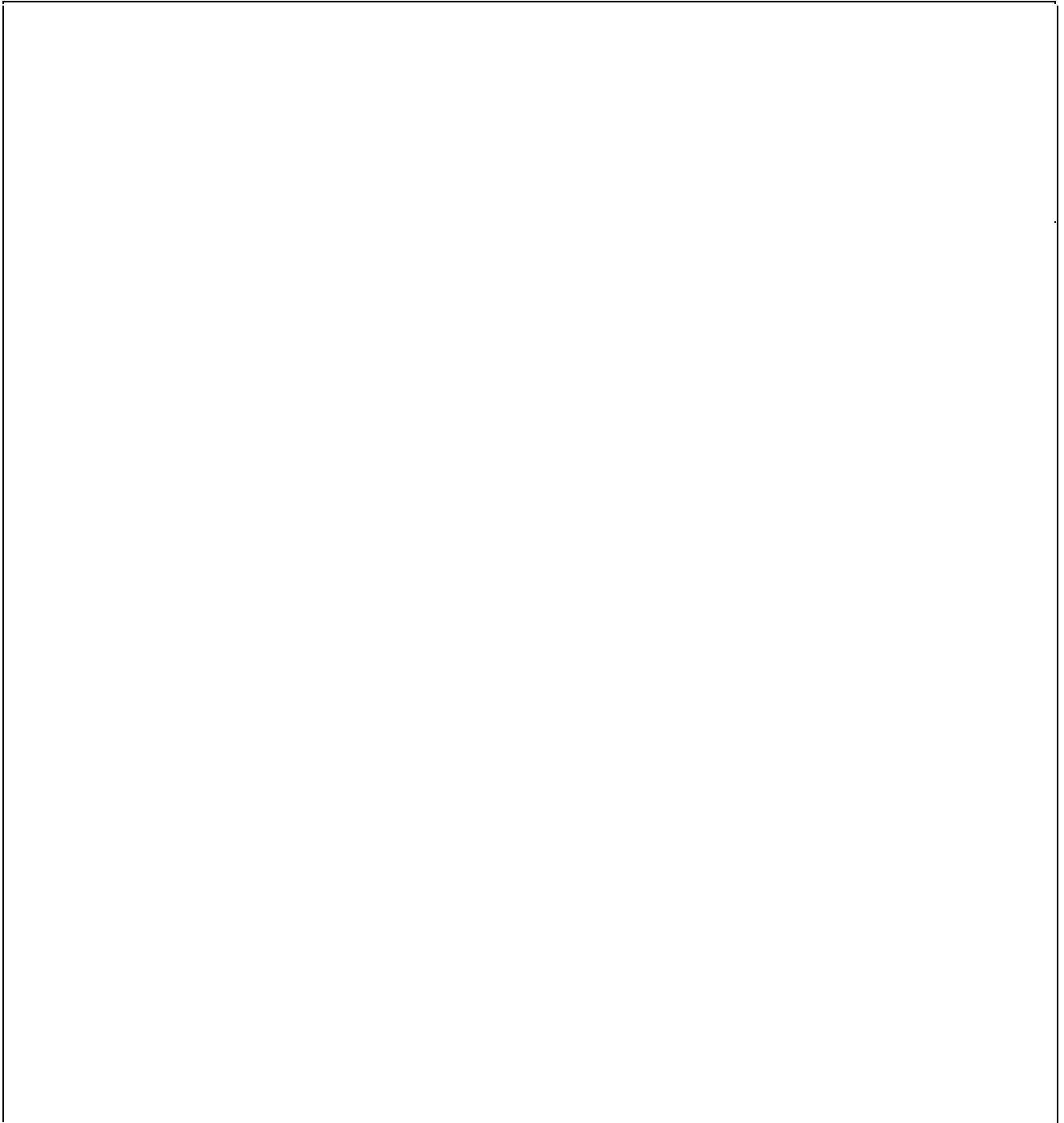
<b>Core Program Information</b>		
Title of Core Program:		
Core Program Director:		
10 Digit ACGME Program ID#:		
Accreditation Status:	Effective Date:	
Next Review Date:	Last Review Date:	Cycle Length:
<b>The signatures of the director of the program and the core program director attest to the completeness and accuracy of the information provided on these forms:</b>		
Signature of Program Director (and Date):		
Signature of Core Program Director (and Date):		

**1. Rationale for creating the program**

Provide a concise description of the program and the rationale for creating it

**2. Planned start date for the first class of residents**

3. Provide a mission statement (the program's core purpose) and 2-3 program aims that the program has the intention of achieving.





**C. FACULTY / RESOURCES**

**1. Program Director Information**

Name:							
Title:							
Address:							
City, State, Zip code:							
Telephone:		FAX:		Email:			
Date First Appointed as Program Director:							
Principal Activity Devoted to Resident Education?				Yes:		No:	
Term of Program Director Appointment:							
Date first appointed as faculty member in the program:							
Number of hours per week Director spends in:							
Clinical Supervision:		Administration:		Research:		Didactics/Teaching:	
Primary Specialty Board Certification:				Most Recent Year:			
Subspecialty Board Certification:				Most Recent Year:			
Number of years spent teaching in this subspecialty:							

a) Is the program director familiar with and does he/she oversee compliance with GME policies and procedures as outlined in the GME Institutional Policies and Procedures (found at <https://www.houstonmethodist.org/education/medical/graduate-medical-education/institutional-policies/>)?  
 ..... ( ) YES ( ) NO

b) CV for the program director.

<b>First Name:</b>		<b>MI:</b>		<b>Last Name:</b>	
<b>Present Position:</b>					
<b>Graduate Medical Education Program Name(s); include dates and names of all residencies and fellowships:</b>					
Certification and Re- Certification Information			Current Licensure Data		
Specialty	Certification Year	Re-Certification Year	State	Date of Expiration (mm/yyyy)	

<b>Academic Appointments - List the past ten years, beginning with your current position.</b>		
<b>Start Date (mm/yyyy)</b>	<b>End Date (mm/yyyy)</b>	<b>Description of Position(s)</b>
	Present	
<b>Concise Summary of Role in Program:</b>		
<b>Current Professional Activities / Committees:</b>		
<b>Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles from the last 5 years (limit of 10):</b>		

**Selected Review Articles, Chapters and/or Textbooks** (Limit of 10 in the last 5 years):

**Participation in Local, Regional, and National Activities / Presentations - Abstracts** (Limit of 10 in the last 5 years):

**If not ABMS board certified, explain equivalent qualifications for Review Committee consideration:**





3. Faculty Curriculum Vitae

<b>First Name:</b> _____					<b>MI:</b> _____		<b>Last Name:</b> _____		
<b>Present Position:</b>									
<b>Graduate Medical Education Program Name(s); include all residencies and fellowships:</b>									
<b>Certification and Re- Certification Information</b>					<b>Current Licensure Data</b>				
<b>Specialty</b>		<b>Certification Year</b>		<b>Re-Certification Year</b>		<b>State</b>		<b>Date of Expiration (mm/yyyy)</b>	
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		Present							
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**First Name: MI: Last Name:**

**Present Position:**

**Graduate Medical Education Program Name(s); include all residencies and fellowships:**





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<b>Present Position:</b>
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<b>Graduate Medical Education Program Name(s); include all residencies and fellowships:</b>
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Certification and Re- Certification Information			Current Licensure Data	
Specialty	Certification Year	Re-Certification Year	State	Date of Expiration (mm/yyyy)
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Start Date (mm/yyyy)	End Date (mm/yyyy)	Description of Position(s)		
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**First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Present Position:** \_\_\_\_\_

**Graduate Medical Education Program Name(s); include all residencies and fellowships:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Certification and Re- Certification Information			Current Licensure Data	
Specialty	Certification Year	Re-Certification Year	State	Date of Expiration (mm/yyyy)

**Academic Appointments - List the past ten years, beginning with your current position.**

Start Date (mm/yyyy)	End Date (mm/yyyy)	Description of Position(s)
	Present	

**Concise Summary of Role in Program:**

\_\_\_\_\_



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	Present			


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**Selected Review Articles, Chapters and/or Textbooks** (Limit of 10 in the last 5 years):

**Participation in Local, Regional, and National Activities / Presentations - Abstracts** (Limit of 10 in the last 5 years):

**If not ABMS board certified, explain equivalent qualifications for Review Committee consideration:**

**4. Non-Physician Faculty Roster**

List alphabetically the non-physician faculty who provide required instruction or supervision of residents in the program.

Name (Position)	Degree	Based Primarily at Site #	Subspecialty / Field	Role In Program	# of Years Teaching as Faculty in Subspecialty

**5. Program Resources**

- a) Do residents have access to specialty-specific and other appropriate reference material in print or electronic format? ..... ( ) YES ( ) NO
- b) Concisely describe the technical, clerical, and other non-physician staff who provide support for the administrative and educational conduct of the program. Is the support of the program in this area satisfactory at all program sites?

- c) How many hours per week are dedicated by the program director to program administration?



d) How many hours per week are allocated to the program coordinator?

**D. RESIDENT APPOINTMENTS**

1. List/describe prerequisite training that is required for entry into the program.

2. Describe how residents will be informed about their assignments and duties during residency. [The answer must confirm that there are goals and objectives for each assignment and for each year, and that these will be readily available (hard copy, electronically, listserv, etc.) to all residents.]

3. Will there be other learners (such as residents from other specialties, subspecialty residents, nurse practitioners, PhD or MD students) in the program, sharing educational or clinical experiences with the residents? If yes, describe the impact those other learners will have on the program's residents.

4. Describe how the program will handle complaints or concerns the residents raise. (The answer must describe the mechanism by which individual residents can address concerns in a confidential and protected manner as well as steps taken to minimize fear of intimidation or retaliation.)

5. Will the program obtain documentation that each Resident has met the eligibility criteria? .....  
.....( ) YES ( ) NO

**F. EVALUATION (RESIDENTS, FACULTY, PROGRAM)**

1. Are residents provided with a description of the skills and competencies that they should be able to demonstrate by the conclusion of the program? ..... ( ) YES ( ) NO
2. Does the faculty provide formative feedback in a timely manner?..... ( ) YES ( ) NO
3. Describe how residents are informed of the performance criteria on which they will be evaluated.

Limit your response to 400 words.

4. Describe the mechanism used to provide the semiannual evaluations of residents (e.g., who meets with the residents and how the results are documented in resident files).

Limit your response to 400 words.

5. Describe the system for evaluating faculty performance as it relates to the educational program.

Limit your response to 400 words.

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6. Describe the mechanisms used for program evaluation, including how the program uses aggregated results of the residents' performance and/or other program evaluation results to improve the program.

Limit your response to 600 words.

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**G. CLINICAL EXPERIENCE AND EDUCATIONAL WORK AND LEARNING ENVIRONMENT**

1. Excluding call from home, what is the projected average number of hours on duty per week per resident?	
---	--

2. What is the projected average number of days per week of in-house call (excluding home call and night float) which residents will be assigned?	
---	--

3. What is the maximum number of consecutive nights of night float assigned to any resident in the program?	
---	--

4. Will residents be allowed to moonlight?     ( ) YES   ( ) NO
5. How does the program monitor resident stress, including mental or emotional conditions inhibiting performance or learning?

--

6. Describe program resources for addressing/improving the learning and working environment?

7. Briefly describe your back up system when clinical care needs exceed the residents' ability (including nights and weekends).

**H. Educational Program**

1. Concisely describe resident educational responsibilities for other residents, medical students, and allied health personnel.

- Describe the manner in which the program ensures that residents are provided with adequate opportunities to assume a major role in the continuing care of patients and have progressive responsibility.

- List the didactic conferences offered for resident education. Do not include specific conference schedules, posters, or advertisements. Use a separate page for conferences at participating institutions. Add rows as needed.

Conference Type: (Basic Science, Journal Club, Pathology, etc.)	<i>Required or Optional</i>	<i>Frequency</i>	Individual(s) or Department Responsible for Conducting Conference

- Comment on the levels of teaching staff participation and resident attendance at program conferences and related educational activities such as journal clubs.

- How does the program ensure that residents are provided with adequate opportunities to observe and to manage patients with a variety of problems and a variety of settings (such as inpatient, outpatient, and emergency department)?

**I. Scholarly Activity**

1. List the staff who provide stimulation and supervision of clinical or laboratory research activity by residents and identify their particular area(s) of expertise.

2. Will the program offer residents the opportunity to participate in scholarly activities? If yes, briefly describe the opportunities and expectations about resident participation.

3. Describe the facilities and resources (including space, equipment, support personnel, funding) that are utilized to support resident research.

**J. BLOCK DIAGRAM FOR THE RESIDENCY PROGRAM**

Complete one for each year of the program and reproduce the diagram as needed. The name of the assignment should be descriptive. The block diagram **MUST** include the **SITE** where the educational assignment occurs. Provide a key for any abbreviations or acronyms used. .

Year: PGY-\_\_

Month	Rotation Type	Site
1		
2		
3		
4		

5		
6		
7		
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12		

Year: PGY-\_\_

Month	Rotation Type	Site
1		
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12		

Year: PGY-\_\_

Month	Rotation Type	Site
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Year: PGY-\_\_

Month	Rotation Type	Site
1		
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Year: PGY-\_\_

Month	Rotation Type	Site
1		
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12		

**ATTACHMENTS**

**Attach the following documents to the application:**

1. Program letters of agreement with participating sites, if applicable.
2. Policy for resident eligibility and selection.
3. Policy for supervision of residents (addresses residents' responsibilities for patient care and progressive responsibility for patient management and faculty responsibilities for supervision)
4. Program policies and procedures for residents' duty hours and work environment
5. Moonlighting policy
6. Overall educational goals for the program)
7. Competency-based goals and objectives for each assignment at each program year of training

8. A blank copy of the forms that will be used to evaluate residents at the completion of each assignment
9. Copies of tools the program will use to provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice
10. A blank copy of the forms that will be used to document the semiannual and final summative evaluations of the residents with feedback
11. A blank copy of the form that residents will use to evaluate the faculty
12. A blank copy of the form that residents will use to evaluate the program

**Submit completed form and all attachments to the GME Office.  
Approval of new programs is subject to [Procedure GME21](#)**