**Application for a New Non-Standard Training (NST) Program**

Please return the completed application and all requested documents (review the last page of this application) via email to [gmeoffice@houstonmethodist.org](mailto:gmeoffice@houstonmethodist.org) no later than **TWO MONTHS** prior to the GMEC meeting date. All new programs are required to have an internal review prior to approval by the Accreditation Subcommittee and GMEC. For the full policy please visit [Procedure 20 on our website](https://www.houstonmethodist.org/education/medical/graduate-medical-education/institutional-policies/). The Accreditation Subcommittee meets on the first Tuesday and GMEC meets on the second Wednesday of each month.

This application must also be used for non-accredited programs seeking approval from GMEC.

**Program Information**

Requesting Department Name

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| Click or tap here to enter text. |

Core Program Director Name and Core Program Name

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| Click or tap here to enter text. |

Proposed Program Start Date

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| Click or tap here to enter text. |

**Program Name**

ACGME provides a list of focus areas as standardized program names. Please review the list [here](https://www.acgme.org/globalassets/pfassets/programrequirements/_nst_approved-focus-areas_july-2024.pdf) and provide the closest related name for your program. If the name is not available, please provide your proposed name and a rationale to request a new focus area to the ACGME.

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| Click or tap here to enter text. |

Length of program in months.

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| Click or tap here to enter text. |

Total number of trainees (by PGY level, if more than one year offered)

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| Click or tap here to enter text. |

Will this program be accredited by another body? Yes/No. If yes, please include the name of the accrediting body and a link to the program requirements or a physical copy if the link is not accessible to the public.

Click or tap here to enter text.

Is certification available to graduates of the program? Yes/No. If certification is provided by a group other than the accrediting body mentioned above, please enter the name here.

Click or tap here to enter text.

Name of most closely related ACGME program and certifying board. You will be required to assess your trainees within the first three months of training using the [ACGME Milestones](https://www.acgme.org/milestones/milestones-by-specialty/).

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| Click or tap here to enter text. |

**Program Director**

Contact information and total FTE dedicated to the administration of the program. [Please refer to the closest related ACGME Program for guidance](https://www.acgme.org/programs-and-institutions/institutions/institutional-application-and-requirements/). (Scroll to the selected topics across program requirements section)

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| --- | --- |
| Program Director Info | |
| Name | Click or tap here to enter text. |
| Office Address | Click or tap here to enter text. |
| Phone Number | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| Total FTEs Dedicated to the administration of the program: | |
| Click or tap here to enter text. | |
| Current Professional Activities/Committees: | |
| Click or tap here to enter text. | |
| List of Peer Reviewed Publications/Journal Articles (limit of 10 in the past 5 years): | |
| Click or tap here to enter text. | |
| List of Review Articles, Chapters, and/or Textbooks (limit of 10 in the past 5 years): | |
| Click or tap here to enter text. | |
| List of Participation in Local, Regional, and National Activities/Presentations-Abstracts (limit of 10 in the past 5 years): | |
| Click or tap here to enter text. | |

Program Director qualifications: Specify required qualifications of the NST Program Director

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| Click or tap here to enter text. |

**Program Coordinator**

Contact information and total FTE dedicated to the administration of the program. [Please refer to the closest related ACGME Program for guidance](https://www.acgme.org/programs-and-institutions/institutions/institutional-application-and-requirements/). (Scroll to the selected topics across program requirements section)

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| Program Coordinator Info | |
| Name | Click or tap here to enter text. |
| Office Address | Click or tap here to enter text. |
| Phone Number | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| Total FTEs Dedicated to the administration of the program: | |
| Click or tap here to enter text. | |

**Participating Sites**

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| **Primary Teaching Site (Site 1)** | |
| Name | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Length of rotation | Click or tap here to enter text. |
| PLA Status *(if applicable)* | Click or tap here to enter text. |
| Educational Rationale | |
| Click or tap here to enter text. | |
| Participating Site (Site 2) | |
| Name | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Length of rotation | Click or tap here to enter text. |
| PLA Status *(if applicable)* | Click or tap here to enter text. |
| Educational Rationale | |
| Click or tap here to enter text. | |
| Participating Site (Site 3) | |
| Name | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Length of rotation | Click or tap here to enter text. |
| PLA Status *(if applicable)* | Click or tap here to enter text. |
| Educational Rationale | |
| Click or tap here to enter text. | |
| Participating Site (Site 4) | |
| Name | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Length of rotation | Click or tap here to enter text. |
| PLA Status *(if applicable)* | Click or tap here to enter text. |
| Educational Rationale | |
| Click or tap here to enter text. | |

**Educational Program**

Provide a brief educational rationale for the creation of the program.

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| Click or tap here to enter text. |

Define the educational goals/aims of the program.

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| Click or tap here to enter text. |

Describe NST trainee responsibilities for patient care, care management, and supervision during the NST program.

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| Click or tap here to enter text. |

Describe how NST trainees will be informed about their assignments and duties. The answer must confirm the availability of goals and objective and the method in which that information will be delivered.

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| Click or tap here to enter text. |

Describe the expected interactions between your residents/fellows and other trainees; describe any potential impact on the core residency program and other fellowship/s (e.g., reduced clinical material available to residents; increased medical student teaching or resident supervision, expanded didactic conferences open to trainees in other programs, etc.)

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| Click or tap here to enter text. |

Describe how personnel, clinical services, and other resources will be made available for the NST programs without adverse impact on the education of residents or fellows in the Sponsoring Institution’s ACGME-accredited programs.

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| Click or tap here to enter text. |

List the conferences, seminars, journal clubs, etc. in which the resident/fellow(s) will participate:

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| **Name of Conference** | **Frequency** | **Required or Elective** | **Individual or Dept. responsible for the session** |
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Describe the basic science and/or clinical research requirements, and/or opportunities available to the resident/fellow(s); note whether (and how much) protected time will be provided for research.

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| Click or tap here to enter text. |

Describe how the resident/fellow(s) will be supervised by the faculty in all patient care settings.

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| Click or tap here to enter text. |

Does the NST program require experience in patient care procedures? If yes, please define procedural experience requirements.

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| Click or tap here to enter text. |

Describe the backup system when clinical needs exceed the NST Trainee’s ability (including nights and weekends)

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| Click or tap here to enter text. |

**Faculty**

List the faculty (both physicians and non-physicians) who will supervise and teach in the program; state how much time each will devote to teaching in “hours-per-week” format.

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| Faculty Name and degree(s) | Board Certification | Board Certification Expiration Date  If MOC, please enter MOC | Role in the program | Hours per week devoted to teaching and supervising fellows | Texas License Number and Expiration date |
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**Evaluation**

List the planned methods for evaluation of and feedback to the resident/fellow(s):

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| Evaluation Type | Frequency | Evaluator |
| Initial Assessment: Milestones closest to ACGME program (within 3 months of start date) | Click or tap here to enter text. | Click or tap here to enter text. |
| Semi-Annual Evaluation | Click or tap here to enter text. | Click or tap here to enter text. |
| Final Summative Evaluation | Click or tap here to enter text. | Click or tap here to enter text. |
| Multisource Evaluation | Click or tap here to enter text. | Click or tap here to enter text. |
| Faculty Evaluation of Fellow | Click or tap here to enter text. | Click or tap here to enter text. |
| Others (list here): | Click or tap here to enter text. | Click or tap here to enter text. |

Describe how the resident/fellow(s) evaluate the faculty and overall program

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| Click or tap here to enter text. |

Describe how the program will handle complains or concerns the NST trainees raise.

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| Click or tap here to enter text. |

**Clinical and Educational Work Hours**

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| Excluding call from home, what is the projected average number of hours on duty per week per NST trainee? | Click or tap here to enter text. |
| What is the projected average number of days per week of in-house call (excluding home call and night float) which NST trainees will be assigned? | Click or tap here to enter text. |
| What is the maximum number of consecutive nights of night float assigned to any resident in the program? | Click or tap here to enter text. |

**Recruitment**

Will this program have fellows belong to the HM Medical Staff or a Medical Staff at another institution in their core specialty as part of the program? (With the ability to bill for their cases)

Click or tap here to enter text.

Briefly describe your strategy for recruiting trainees, faculty, and staff with diversity and inclusion in mind

Click or tap here to enter text.

**Department Approvals:**

Click or tap here to enter text. Click or tap to enter a date.

Proposed Program Director Signature Date Signed

Click or tap here to enter text. Click or tap to enter a date.

Core Program Director Signature Date Signed

Click or tap here to enter text.

Department Chair Name

Click or tap here to enter text. Click or tap to enter a date.

Department Chair Signature Date Signed

Click or tap here to enter text.

Division Chair Name *(if applicable)*

Click or tap here to enter text. Click or tap to enter a date.

Division Chair Signature Date Signed

**Additional Documentation Required**

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|  | 1. If this program is accredited by another body, please include a copy of the requirements when a public link is not available |
|  | 1. Program Letter of Agreement Drafts for all participating sites, if applicable. Please reach out to Shelby Raven at [saraven@houstonmethodist.org](mailto:saraven@houstonmethodist.org) to begin this process |
|  | 1. Block diagram/rotation schedule. [Please refer to these templates for guidance](https://houstonmethodist1-my.sharepoint.com/:b:/g/personal/gechevarria_houstonmethodist_org/EaofzFCJIcdGpFcWNUPkVioBxRfnh_q1tJAEtqYOU__tfg?e=5F25pw) |
|  | 1. Competency-based rotation specific goals and objectives for each level of training. [Please use this template for guidance.](https://houstonmethodist1-my.sharepoint.com/:w:/g/personal/gechevarria_houstonmethodist_org/EU5ObQZNYiVJhzPj-AcF8PIBZEF3Ps63mQSqVKISs-lRdg?e=1PjBXK) |
|  | 1. Eligibility and Selection Policy (program specific). Prior to writing your program specific policy, please review Procedure 3 [here](https://www.houstonmethodist.org/education/medical/graduate-medical-education/institutional-policies/) to ensure the program policy aligns with the institutional policy |
|  | 1. Transition of Care Policy (program specific). Prior to writing your program specific policy, please review Procedure 27 [here](https://www.houstonmethodist.org/education/medical/graduate-medical-education/institutional-policies/) to ensure the program policy aligns with the institutional policy |
|  | 1. Supervision Policy (program specific). Prior to writing your program specific policy, please review Procedure 8 [here](https://www.houstonmethodist.org/education/medical/graduate-medical-education/institutional-policies/) to ensure the program policy aligns with the institutional policy |
|  | 1. Clinical and Educational Work Hours Policy (Duty Hours) (program specific) |
|  | 1. Moonlighting Policy (program specific). Prior to writing your program specific policy, please review Procedure 13 [here](https://www.houstonmethodist.org/education/medical/graduate-medical-education/institutional-policies/) to ensure the program policy aligns with the institutional policy |
|  | 1. Evaluation policy (Must include requirement for Initial assessment to be completed no later than three months from the start date and that trainee will be directly supervised until the ACGME milestones have been achieved, Semi-Annual Evaluation, and Final Summative Evaluation) (program specific). Prior to writing your program specific policy, please review Procedure 12 [here](https://www.houstonmethodist.org/education/medical/graduate-medical-education/institutional-policies/) to ensure the program policy aligns with the institutional policy |
|  | 1. A blank copy of the forms that will be used to evaluate residents at the completion of each assignment (faculty evaluation of resident) |
|  | 1. 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 |
|  | 1. A blank copy of the forms that will be used to document the Initial assessment against the milestones, semiannual, and final summative evaluations of the residents with feedback |
|  | 1. A blank copy of the form that residents will use to evaluate the faculty |
|  | 1. A blank copy of the form that residents will use to evaluate the program |
|  | 1. A blank copy of the form that non-faculty team members will use to evaluate the resident |
|  | 1. Letter of Financial Support. Please visit [our page](https://www.houstonmethodist.org/education/medical/graduate-medical-education/institutional-policies/) and scroll to Procedure 21 to find the latest version of Letter of Financial Support |
|  | 1. [TMB Application](https://www.tmb.state.tx.us/page/Board-Approved-Fellowship). The check will be requested after the program has been approved by the GMEC |
|  | 1. Copy of the Scope of Practice (list of procedures and supervision level) |