Definition of Graduate Medical Education Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellance, compassion, cultural sensitivity, professionall during generations of physicians to serve the public. Practice patients future generations of physicians to serve the public. Practice patients future generations of physicians to serve the public. Practice patients future generations of physicians to serve the public. Practice patients future generations of physicians to serve the public. Practice patients future generations of physicians to serve the public. Practice patients future generations of physicians to serve the public. Practice patients future generations of physicians to serve the public. Practice patients established during graduate medical education persist many years later. (None) Graduate medical education has as a core tenot the graded authority and residents to tatin the knowledge, skills, attives, judgment, and empily required for autonomous practice. Graduate medical education has as foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical education, develops physicians brings to medical care, not continues foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medica	Requirement Number -		Reformatted	
Graduate medical education is the crucial step of professional       Definition of Graduate Medical Education is the crucial step of professional         development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents       Definition of Graduate medical school and auton         learn to provide optimal patient care under the supervision of facuity       optimal patient care under the supervision of facuity       optimal patient care under the supervision of facuity         members who not only instruct, but serve as role models of accollence,       compassion, cultural sensitivity, professionalism, and scholarship.       Graduate medical education transfor         Graduate medical education transforms medical students into physician       Graduate medical education transfor       generations of physicians to serve in provide optimal patient care. The core of patient patient, patient care. The care of patients is undertaken with       responsibility for patient care. The care of patients is undertaken with         appropriate faculty supervision and conditional independence, allowing       responsibility for patient care. The care of patient is undertaken with       Graduate medical education has as a core tenet the graded authority and         responsibility for patient care. The care of patients is undertaken with       responsibility for patient care. The care of patient set well       physicians the knowledge, skills, attitudes, judgment, and empathy         required for autonomous practice. Graduate medical education develops       requined for autonomous practice. The care of patient ase un	Roman Numerals	Requirement Language	Requirement Number	Requirem
Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve.       Graduate medical education values affordable, quality care; and the health of the populations they serve.         Graduate medical education occurs in clinical settings that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.       Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a hurmanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments do graduate medical education and the well-being       Graduate medical education occurs in direct education and environment that emphasizes op in and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being       Graduate medical education occurs in a variety of clinical learning environments committed to graduate	Int.A.	Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns	[None]	Graduate medical education is the obstween medical school and autono phase of the continuum of medical optimal patient care under the supe instruct, but serve as role models o sensitivity, professionalism, and sc Graduate medical education transfo scholars who care for the patient, p create and integrate new knowledge generations of physicians to serve
	Int.A. (Continued)	responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments. Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments, residents, fellows, faculty members, students, and all members		responsibility for patient care. The of appropriate faculty supervision and residents to attain the knowledge, s required for autonomous practice. Of physicians who focus on excellence affordable, quality care; and the heat Graduate medical education values physicians brings to medical care, a psychologically safe learning enviro Graduate medical education occurs foundation for practice-based and heat development of the physician, begut faculty modeling of the effacement environment that emphasizes joy in rigor, and discovery. This transform and intellectually demanding and of environments committed to graduat of patients, residents, fellows, faculty

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e crucial step of professional development nomous clinical practice. It is in this vital al education that residents learn to provide pervision of faculty members who not only of excellence, compassion, cultural scholarship.

sforms medical students into physician patient's family, and a diverse community; lge into practice; and educate future e the public. Practice patterns established on persist many years later.

as a core tenet the graded authority and e care of patients is undertaken with nd conditional independence, allowing , skills, attitudes, judgment, and empathy e. Graduate medical education develops nce in delivery of safe, equitable, health of the populations they serve. es the strength that a diverse group of e, and the importance of inclusive and rironments.

Irs in clinical settings that establish the d lifelong learning. The professional gun in medical school, continues through nt of self-interest in a humanistic in curiosity, problem-solving, academic rmation is often physically, emotionally, occurs in a variety of clinical learning uate medical education and the well-being culty members, students, and all members

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
	<b>Definition of Specialty</b> Residencies in emergency medicine prepare physicians for the practice of emergency medicine. These programs must teach the fundamental skills,		<b>Definition of Specialty</b> Residencies in emergency medicin emergency medicine. These progra
	knowledge, and humanistic qualities that constitute the foundations of emergency medicine practice. These programs provide progressive responsibility for and experience in these areas to enable effective management of clinical problems. Residents must have the opportunity, under the guidance and supervision of a qualified faculty member, to develop a satisfactory level of clinical maturity, judgment, and technical skill. On completion of the program, residents should be capable of practicing emergency medicine, able to incorporate new skills and		knowledge, and humanistic qualitie emergency medicine practice. The responsibility for and experience in management of clinical problems. I under the guidance and supervision develop a satisfactory level of clinic skill. On completion of the program practicing emergency medicine, ab
Int.B.	knowledge during their careers, and able to monitor their own physical and mental well-being.	[None]	knowledge during their careers, and mental well-being.
	Length of Educational Program		
Int.C.	Residency programs in emergency medicine are configured in 36-month and 48-month formats, and must include a minimum of 36 months of clinical education. (Core)	4.1.	Length of Program Residency programs in emergency and 48-month formats, and must in clinical education. (Core)
Int.C.1.	Programs utilizing the 48-month format must ensure that all of the clinical, educational, and milestone elements contained in these Program Requirements are met, and must provide additional in-depth experience in areas related to emergency medicine, such as medical education, clinical- or laboratory-based research, or global health. An educational justification describing the additional educational goals and outcomes to be achieved by residents in the incremental 12 months of education must be submitted to the Review Committee prior to implementation, and at each subsequent accreditation review of residency programs of 48 months' duration. (Core)	4.1.a.	Programs utilizing the 48-month for educational, and milestone elemen Requirements are met, and must p areas related to emergency medici or laboratory-based research, or gle describing the additional education by residents in the incremental 12 r to the Review Committee prior to in accreditation review of residency pr
l.	Oversight	Section 1	Section 1: Oversight
	Sponsoring Institution The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.		Sponsoring Institution The Sponsoring Institution is the the ultimate financial and acader graduate medical education, con Requirements.
I.A.	When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.	[None]	When the Sponsoring Institution program, the most commonly ut program is the primary clinical s
I.A.1.	The program must be sponsored by one ACGME-accredited Sponsoring Institution.	1.1.	The program must be sponsored Sponsoring Institution.
I.B.	Participating Sites A participating site is an organization providing educational experiences or educational assignments/rotations for residents.	[None]	Participating Sites A participating site is an organiz experiences or educational assig

cine prepare physicians for the practice of grams must teach the fundamental skills, ities that constitute the foundations of nese programs provide progressive in these areas to enable effective s. Residents must have the opportunity, sion of a qualified faculty member, to nical maturity, judgment, and technical am, residents should be capable of able to incorporate new skills and and able to monitor their own physical and

cy medicine are configured in 36-month include a minimum of 36 months of

format must ensure that all of the clinical, ents contained in these Program t provide additional in-depth experience in icine, such as medical education, clinicalglobal health. An educational justification onal goals and outcomes to be achieved 2 months of education must be submitted o implementation, and at each subsequent programs of 48 months' duration. (Core)

he organization or entity that assumes lemic responsibility for a program of consistent with the ACGME Institutional

on is not a rotation site for the utilized site of clinical activity for the I site.

ed by one ACGME-accredited

ization providing educational signments/rotations for residents.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement Language
I.B.1.	The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)	1.2.	The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)
I.B.2.	There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)	1.3.	There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a require assignment. (Core)
I.B.2.a)	The PLA must:	[None]	
I.B.2.a).(1)	be renewed at least every 10 years; and, (Core)	1.3.a.	The PLA must be renewed at least every 10 years. (Core)
I.B.2.a).(2)	be approved by the designated institutional official (DIO). (Core)	1.3.b.	The PLA must be approved by the designated institutional officia (DIO). (Core)
I.B.3.	The program must monitor the clinical learning and working environment at all participating sites. (Core)	1.4.	The program must monitor the clinical learning and working environment at all participating sites. (Core)
I.B.3.a).	At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)	1.5.	At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration w the program director. (Core)
I.B.4.	The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)	1.6.	The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) more through the ACGME's Accreditation Data System (ADS). (Co
I.B.4.a)	The program should be based at the primary clinical site. (Core)	1.6.a.	The program should be based at the primary clinical site. (Core)
I.B.4.b)	Programs using multiple participating sites must ensure the provision of a unified educational experience for the residents. (Core)	1.6.b.	Programs using multiple participating sites must ensure the provision of unified educational experience for the residents. (Core)
I.B.4.b).(1)	Each participating site must offer significant educational opportunities to the overall program. (Core)	1.6.c.	Each participating site must offer significant educational opportunities the overall program. (Core)
I.B.4.c)	Required rotations to participating sites that are geographically distant from the sponsoring institution must offer educational opportunities unavailable locally that significantly augment residents' overall educational experience. (Core)	1.6.d.	Required rotations to participating sites that are geographically distant the sponsoring institution must offer educational opportunities unavaila locally that significantly augment residents' overall educational experie (Core)
I.B.4.c).(1)	The program should ensure that residents are not unduly burdened by required rotations at geographically distant sites. (Core)	1.6.e.	The program should ensure that residents are not unduly burdened by required rotations at geographically distant sites. (Core)
I.C.	Workforce Recruitment and Retention The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)	1.7.	Workforce Recruitment and Retention The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, sen administrative GME staff members, and other relevant members of academic community. (Core)
I.D.	Resources	1.8.	Resources The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident educati (Core)
I.D.1.	The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)	1.8.	Resources The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident educati (Core)

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Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
I.D.1.a)	The program must demonstrate the availability of educational resources, including the presence of residents in other specialties, to enhance the training of the emergency medicine residents. (Core)	1.8.a.	The program must demonstrate th including the presence of residents training of the emergency medicine
I.D.1.b)	At every site in which the emergency department provides resident education, the following must be provided: (Core)	1.8.b.	At every site in which the emergen education, the following must be p
I.D.1.b).(1)	adequate space for patient care; (Core)	1.8.b.1.	adequate space for patient care; (
I.D.1.b).(2)	space for clinical support services; (Core)	1.8.b.2.	space for clinical support services;
I.D.1.b).(3)	diagnostic imaging completed and results available on a timely basis, especially those required on a STAT basis; (Core)	1.8.b.3.	diagnostic imaging completed and especially those required on a STA
I.D.1.b).(4)	laboratory studies completed and results available on a timely basis, especially those required on a STAT basis; (Core)	1.8.b.4.	laboratory studies completed and especially those required on a STA
I.D.1.b).(5)	office space for core physician faculty members, and residents; (Core)	1.8.b.5.	office space for core physician fac
I.D.1.b).(6)	instructional space; (Core)	1.8.b.6.	instructional space; (Core)
I.D.1.b).(7)	information systems; and, (Core)	1.8.b.7.	information systems; and, (Core)
I.D.1.b).(8)	appropriate security services and systems to ensure a safe working environment. (Core)	1.8.b.8.	appropriate security services and services and servironment. (Core)
I.D.1.c)	Clinical support services must include nursing, clerical, intravenous, electrocardiogram (EKG), respiratory therapy, transporter, and phlebotomy, and must be available on a 24-hour basis so that residents are not burdened with these duties. (Core)	1.8.c.	Clinical support services must inclue electrocardiogram (EKG), respirate and must be available on a 24-hou burdened with these duties. (Core)
I.D.1.d)	Office space for program coordinators and additional support personnel must be provided at the primary clinical site. (Core)	1.8.d.	Office space for program coordina must be provided at the primary cl
I.D.1.e)	Each clinical site must provide timely consultation from services based on a patient's acuity. (Core)	1.8.e.	Each clinical site must provide time a patient's acuity. (Core)
I.D.1.e).(1)	If any clinical services are not available for consultation or admission, each clinical site must have a written protocol for provision of these services elsewhere. (Core)	1.8.e.1.	If any clinical services are not avai clinical site must have a written pro elsewhere. (Core)
I.D.1.e).(2)	Each clinical site must ensure timely consultation decisions by a provider from admitting and consulting services with decision making authority. (Core)	1.8.e.2.	Each clinical site must ensure time from admitting and consulting serv (Core)
I.D.1.f)	The patient population must include patients of all ages and genders as well as patients with a wide variety of clinical problems. (Core)	1.8.f.	The patient population must includ well as patients with a wide variety
I.D.1.g)	The primary clinical site to which residents rotate must have at least 30,000 emergency department visits annually. (Core)	1.8.g.	The primary clinical site to which re 30,000 emergency department vis
I.D.1.g).(1)	The primary clinical site should have a significant number of critically ill or critically injured patients constituting at least three percent or 1200 (whichever is greater) of the emergency department patients per year. (Core)	1.8.g.1.	The primary clinical site should hat critically injured patients constitutin (whichever is greater) of the emerge (Core)
I.D.1.g).(2)	All other emergency departments to which residents rotate for four months or longer should each have at least 30,000 emergency department visits annually. (Core)	1.8.g.2.	All other emergency departments for longer should each have at least annually. (Core)
I.D.1.h)	Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians. (Core)	1.8.h.	Residents must be provided with p communication and interaction wit
I.D.2.	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:	1.9.	The program, in partnership with ensure healthy and safe learning promote resident well-being and
I.D.2.a)	access to food while on duty; (Core)	1.9.a.	access to food while on duty; (C

#### ement Language

the availability of educational resources, nts in other specialties, to enhance the ine residents. (Core)

ency department provides resident provided: (Core)

(Core)

es; (Core)

nd results available on a timely basis, TAT basis; (Core)

d results available on a timely basis,

TAT basis; (Core)

aculty members, and residents; (Core)

d systems to ensure a safe working

clude nursing, clerical, intravenous, atory therapy, transporter, and phlebotomy, our basis so that residents are not re)

nators and additional support personnel clinical site. (Core)

mely consultation from services based on

vailable for consultation or admission, each protocol for provision of these services

mely consultation decisions by a provider ervices with decision making authority.

ude patients of all ages and genders as ety of clinical problems. (Core)

n residents rotate must have at least *r*isits annually. (Core)

have a significant number of critically ill or iting at least three percent or 1200 ergency department patients per year.

s to which residents rotate for four months ast 30,000 emergency department visits

n prompt, reliable systems for vith supervisory physicians. (Core)

vith its Sponsoring Institution, must ing and working environments that nd provide for:

(Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Paquirom
	safe, quiet, clean, and private sleep/rest facilities available and		Requirem safe, quiet, clean, and private sle
	accessible for residents with proximity appropriate for safe patient		accessible for residents with pro
I.D.2.b)	care; (Core)	1.9.b.	care; (Core)
	clean and private facilities for lactation that have refrigeration		clean and private facilities for la
I.D.2.c)	capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	capabilities, with proximity appr
	security and safety measures appropriate to the participating site;		security and safety measures ap
I.D.2.d)	and, (Core)	1.9.d.	and, (Core)
	accommodations for residents with disabilities consistent with the		accommodations for residents w
I.D.2.e)	Sponsoring Institution's policy. (Core)	1.9.e.	Sponsoring Institution's policy.
	Residents must have ready access to specialty-specific and other		Residents must have ready acce
	appropriate reference material in print or electronic format. This		appropriate reference material ir
. – .	must include access to electronic medical literature databases with		include access to electronic med
I.D.3.	full text capabilities. (Core)	1.10.	capabilities. (Core)
	Other Learners and Health Care Personnel		
			Other Learners and Health Care
	The presence of other learners and other health care personnel,		The presence of other learners a
	including, but not limited to residents from other programs,		including, but not limited to resid
	subspecialty fellows, and advanced practice providers, must not		subspecialty fellows, and advan
I.E.	negatively impact the appointed residents' education. (Core)	1.11.	negatively impact the appointed
II.	Personnel	Section 2	Section 2: Personnel
			Program Director
			There must be one faculty memb
			with authority and accountability
II.A.	Program Director	2.1.	compliance with all applicable p
			Program Director
	There must be one faculty member appointed as program director		There must be one faculty memb
	with authority and accountability for the overall program, including		with authority and accountability
II.A.1.	compliance with all applicable program requirements. (Core)	2.1.	compliance with all applicable p
	The Sponsoring Institution's GMEC must approve a change in		The Sponsoring Institution's GM
	program director and must verify the program director's licensure		program director and must verify
II.A.1.a)	and clinical appointment. (Core)	2.2.	and clinical appointment. (Core)
	Final approval of the program director resides with the Review		Final approval of the program di
II.A.1.a).(1)	Committee. (Core)	2.2.a.	Committee. (Core)
	The program must demonstrate retention of the program director for		The program must demonstrate
	a length of time adequate to maintain continuity of leadership and	2.2	a length of time adequate to mai
II.A.1.b)	program stability. (Core)	2.3.	program stability. (Core)
	The program director and, as applicable, the program's leadership		The program director and, as ap
II A 2	team, must be provided with support adequate for administration of	24	team, must be provided with sup
II.A.2.	the program based upon its size and configuration. (Core)	2.4.	the program based upon its size

sleep/rest facilities available and roximity appropriate for safe patient

lactation that have refrigeration propriate for safe patient care; (Core) appropriate to the participating site;

with disabilities consistent with the v. (Core)

cess to specialty-specific and other in print or electronic format. This must edical literature databases with full text

e Personnel and other health care personnel, sidents from other programs, inced practice providers, must not ed residents' education. (Core)

nber appointed as program director ity for the overall program, including program requirements. (Core)

mber appointed as program director ity for the overall program, including program requirements. (Core)

MEC must approve a change in ify the program director's licensure e)

director resides with the Review

e retention of the program director for aintain continuity of leadership and

applicable, the program's leadership upport adequate for administration of ze and configuration. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
	The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core)		The program leadership, in aggreg equal to a dedicated minimum time the program. This may be time spe divided between the program direc assistant) program directors as foll
	Number of Approved Resident Positions:18-20   Minimum Support Required (FTE): 0.6   Assistant or Associate Program Directors: 1		Number of Approved Resident Pos Required (FTE): 0.6   Assistant or
	Number of Approved Resident Positions:21-25   Minimum Support Required (FTE): 0.7   Assistant or Associate Program Directors: 1		Number of Approved Resident Pos Required (FTE): 0.7   Assistant or
	Number of Approved Resident Positions:26-30   Minimum Support Required (FTE): 0.8   Assistant or Associate Program Directors: 1		Number of Approved Resident Pos Required (FTE): 0.8   Assistant or
	Number of Approved Resident Positions:31-35   Minimum Support Required (FTE): 0.85   Assistant or Associate Program Directors: 1		Number of Approved Resident Pos Required (FTE): 0.85   Assistant o
	Number of Approved Resident Positions:36-40   Minimum Support Required (FTE): 1   Assistant or Associate Program Directors: 2		Number of Approved Resident Pos Required (FTE): 1   Assistant or A
	Number of Approved Resident Positions:41-45   Minimum Support Required (FTE): 1.1   Assistant or Associate Program Directors: 2		Number of Approved Resident Pos Required (FTE): 1.1   Assistant or
	Number of Approved Resident Positions:46-50   Minimum Support Required (FTE): 1.2   Assistant or Associate Program Directors: 2		Number of Approved Resident Pos Required (FTE): 1.2   Assistant or
II.A.2.a)	Number of Approved Resident Positions:51-53   Minimum Support Required (FTE): 1.2   Assistant or Associate Program Directors: 2	2.4.a.	Number of Approved Resident Pos Required (FTE): 1.2   Assistant or

egate, must be provided with support ne specified below for administration of pent by the program director only or ector and one or more associate (or ollows: (Core)

ositions:18-20 | Minimum Support or Associate Program Directors: 1

ositions:21-25 | Minimum Support or Associate Program Directors: 1

ositions:26-30 | Minimum Support or Associate Program Directors: 1

ositions:31-35 | Minimum Support t or Associate Program Directors: 1

ositions:36-40 | Minimum Support Associate Program Directors: 2

ositions:41-45 | Minimum Support or Associate Program Directors: 2

ositions:46-50 | Minimum Support or Associate Program Directors: 2

ositions:51-53 | Minimum Support or Associate Program Directors: 2

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
	Number of Approved Resident Positions:54-55   Minimum Support Required (FTE): 1.3   Assistant or Associate Program Directors: 3		Number of Approved Resident Pos Required (FTE): 1.3   Assistant or
	Number of Approved Resident Positions:56-60   Minimum Support Required (FTE): 1.4   Assistant or Associate Program Directors: 3		Number of Approved Resident Pos Required (FTE): 1.4   Assistant or
	Number of Approved Resident Positions:61-65   Minimum Support Required (FTE): 1.5   Assistant or Associate Program Directors: 3		Number of Approved Resident Pos Required (FTE): 1.5   Assistant or
	Number of Approved Resident Positions:66-70   Minimum Support Required (FTE): 1.55   Assistant or Associate Program Directors: 3		Number of Approved Resident Pos Required (FTE): 1.55   Assistant o
	Number of Approved Resident Positions:71-75   Minimum Support Required (FTE): 1.55   Assistant or Associate Program Directors: 3		Number of Approved Resident Pos Required (FTE): 1.55   Assistant o
	Number of Approved Resident Positions:76-80   Minimum Support Required (FTE): 1.55   Assistant or Associate Program Directors: 3		Number of Approved Resident Pos Required (FTE): 1.55   Assistant o
	Number of Approved Resident Positions:81-85   Minimum Support Required (FTE): 1.55   Assistant or Associate Program Directors: 3		Number of Approved Resident Pos Required (FTE): 1.55   Assistant o
	Number of Approved Resident Positions:86-90   Minimum Support Required (FTE): 1.55   Assistant or Associate Program Directors: 3		Number of Approved Resident Pos Required (FTE): 1.55   Assistant c
	Number of Approved Resident Positions:91-95   Minimum Support Required (FTE): 1.55   Assistant or Associate Program Directors: 3		Number of Approved Resident Pos Required (FTE): 1.55   Assistant o
II.A.2.a) - (Continued)	Number of Approved Resident Positions:96-100   Minimum Support Required (FTE): 1.55   Assistant or Associate Program Directors: 3	2.4.a (Continued)	Number of Approved Resident Pos Required (FTE): 1.55   Assistant of
II.A.2.b)	From the support table listed above, program directors of programs approved for 18-35 residents must be provided no less than 35 percent support and program directors of programs approved for 36 or more residents must be provided no less than 50 percent support. (Core)	2.4.b.	From the support table listed above approved for 18-35 residents must support and program directors of p residents must be provided no less
ША 2	Qualifications of the program directory	2.5.	Qualifications of the Program Di The program director must poss three years of documented educ experience, or qualifications acc
II.A.3.	Qualifications of the program director:	2.3.	(Core) Qualifications of the Program Di
II A 2 a)	must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications accontable to the Boview Committee: (Core)	2.5	The program director must poss three years of documented educ experience, or qualifications acc
II.A.3.a)	qualifications acceptable to the Review Committee; (Core)	2.5.	(Core)

ositions:54-55 | Minimum Support or Associate Program Directors: 3

ositions:56-60 | Minimum Support or Associate Program Directors: 3

ositions:61-65 | Minimum Support or Associate Program Directors: 3

ositions:66-70 | Minimum Support t or Associate Program Directors: 3

ositions:71-75 | Minimum Support t or Associate Program Directors: 3

ositions:76-80 | Minimum Support t or Associate Program Directors: 3

ositions:81-85 | Minimum Support t or Associate Program Directors: 3

ositions:86-90 | Minimum Support t or Associate Program Directors: 3

ositions:91-95 | Minimum Support t or Associate Program Directors: 3

ositions:96-100 | Minimum Support t or Associate Program Directors: 3

ove, program directors of programs st be provided no less than 35 percent programs approved for 36 or more ss than 50 percent support. (Core)

#### Director

ssess specialty expertise and at least ucational and/or administrative cceptable to the Review Committee.

#### Director

ssess specialty expertise and at least ucational and/or administrative cceptable to the Review Committee.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
II.A.3.b)	must include current certification in the specialty for which they are the program director by the American Board of Emergency Medicine (ABEM) or by the American Osteopathic Board of Emergency Medicine (AOBEM), or specialty qualifications that are acceptable to the Review Committee; and, (Core)	2.5.a.	The program director must poss specialty for which they are the Board of Emergency Medicine (Al Board of Emergency Medicine (Al are acceptable to the Review Co
II.A.3.b).(1)	The Review Committee for Emergency Medicine will only consider ABMS and AOA board certification as acceptable program director certification qualifications. <sup>(Core)</sup>	2.5.a.1.	The Review Committee for Emerge and AOA board certification as acc qualifications. (Core)
II.A.3.c)	must include ongoing clinical activity. (Core)	2.5.b.	The program director must dem (Core)
II.A.3.d)	must be a core physician faculty member; (Core)	2.5.c.	The program director must be a co
II.A.3.e)		2.5.d.	The program director must have de role. (Core)
II.A.3.f)	must include evidence of ongoing involvement in scholarly activity, including peer-reviewed publications. (Core)	2.5.e.	The program director must include scholarly activity, including peer-re
	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care.		Program Director Responsibilitie The program director must have accountability for: administratio scholarly activity; resident recru promotion of residents, and disc residents; and resident educatio
II.A.4.	(Core)	2.6.	(Core)
II.A.4.a)	The program director must:	[None]	
II.A.4.a).(1)	be a role model of professionalism; (Core)	2.6.a.	The program director must be a
II.A.4.a).(2)	design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)	2.6.b.	The program director must design fashion consistent with the need the Sponsoring Institution, and t
II.A.4.a).(3)	administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)	2.6.c.	The program director must adm environment conducive to educa ACGME Competency domains. (
II.A.4.a).(3)	have the authority to approve or remove physicians and non- physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and	2.6.d.	The program director must have physicians and non-physicians sites, including the designation develop and oversee a process approval. (Core)
II.A.4.a).(5)	have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)	2.6.e.	The program director must have from supervising interactions ar not meet the standards of the pr
II.A.4.a).(6)	submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)	2.6.f.	The program director must subr required and requested by the D
II.A.4.a).(7)	provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)	2.6.g.	The program director must prov environment in which residents concerns, report mistreatment, a manner as appropriate, without (Core)

#### ement Language

essess current certification in the be program director by the American (ABEM) or by the American Osteopathic (AOBEM), or specialty qualifications that Committee. (Core)

rgency Medicine will only consider ABMS acceptable program director certification

monstrate ongoing clinical activity.

core physician faculty member. (Core) demonstrated experience in a leadership

le evidence of ongoing involvement in reviewed publications. (Core)

#### ities

ve responsibility, authority, and tion and operations; teaching and cruitment and selection, evaluation, and isciplinary action; supervision of tion in the context of patient care.

a role model of professionalism. (Core) sign and conduct the program in a eds of the community, the mission(s) of d the mission(s) of the program. (Core)

minister and maintain a learning ucating the residents in each of the s. (Core)

ve the authority to approve or remove is as faculty members at all participating on of core faculty members, and must is to evaluate candidates prior to

ve the authority to remove residents and/or learning environments that do program. (Core)

bmit accurate and complete information DIO, GMEC, and ACGME. (Core)

ovide a learning and working ts have the opportunity to raise t, and provide feedback in a confidential ut fear of intimidation or retaliation.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to		The program director must ensu Sponsoring Institution's policies grievances and due process, ind suspend or dismiss, or not to pr
II.A.4.a).(8)	promote or renew the appointment of a resident; (Core)	2.6.h.	resident. (Core)
II.A.4.a).(9)	ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)	2.6.i.	The program director must ensu Sponsoring Institution's policies non-discrimination. (Core)
II.A.4.a).(9).(a)	Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Residents must not be required or restrictive covenant. (Core)
II.A.4.a).(10)	document verification of education for all residents within 30 days of completion of or departure from the program; and, (Core)	2.6.j.	The program director must docuresidents within 30 days of com program. (Core)
II.A.4.a).(11)	provide verification of an individual resident's education upon the resident's request, within 30 days; and (Core)	2.6.k.	The program director must prov resident's education upon the re (Core)
II.A.4.a).(12)	provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)	2.6.1.	The program director must prov interview with information relate relevant specialty board examin
П.В.	Faculty Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population. Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.		Faculty Faculty members are a foundati education – faculty members tea patients. Faculty members prove residents to grow and become p receive the highest quality of ca generations of physicians by de commitment to excellence in tea professionalism, and a dedication members experience the pride a development of future colleague by the opportunity to teach and employing a scholarly approach through the graduate medical eq of the individual and the popula Faculty members ensure that pa expected from a specialist in the to the needs of the patients, res Faculty members provide approp promote patient safety. Faculty environment by acting in a profe- well-being of the residents and a
II.B.1.	There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)	2.7.	There must be a sufficient numb competence to instruct and sup
II.B.2.	Faculty members must:	[None]	•
II.B.2.a)	be role models of professionalism; (Core)	2.8.	Faculty Responsibilities Faculty members must be role n

#### ement Language

sure the program's compliance with the ies and procedures related to including when action is taken to promote or renew the appointment of a

sure the program's compliance with the ies and procedures on employment and

ed to sign a non-competition guarantee

cument verification of education for all mpletion of or departure from the

ovide verification of an individual resident's request, within 30 days.

ovide applicants who are offered an ated to the applicant's eligibility for the ination(s). (Core)

ational element of graduate medical teach residents how to care for ovide an important bridge allowing e practice-ready, ensuring that patients care. They are role models for future demonstrating compassion, teaching and patient care, otion to lifelong learning. Faculty e and joy of fostering the growth and oues. The care they provide is enhanced and model exemplary behavior. By ch to patient care, faculty members, education system, improve the health olation.

patients receive the level of care the field. They recognize and respond esidents, community, and institution. ropriate levels of supervision to by members create an effective learning ofessional manner and attending to the d themselves.

nber of faculty members with upervise all residents. (Core)

models of professionalism. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
II.B.2.b)	demonstrate commitment to the delivery of safe, equitable, high- quality, cost-effective, patient-centered care; (Core)	2.8.a.	Faculty members must demons safe, equitable, high-quality, cos (Core)
II.B.2.c)	demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)	2.8.b.	Faculty members must demonst of residents, including devoting program to fulfill their superviso (Core)
II.B.2.d)	administer and maintain an educational environment conducive to educating residents; (Core)	2.8.c.	Faculty members must administ environment conducive to educa
II.B.2.e)	regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)	2.8.d.	Faculty members must regularly discussions, rounds, journal clu
II.B.2.f)	pursue faculty development designed to enhance their skills at least annually: (Core)	2.8.e.	Faculty members must pursue f enhance their skills at least ann
II.B.2.f).(1)	as educators and evaluators; (Detail)	2.8.e.1.	as educators and evaluators; (D
II.B.2.f).(2)	in quality improvement, eliminating health inequities, and patient safety; (Detail)	2.8.e.2.	in quality improvement, eliminat safety; (Detail)
II.B.2.f).(3)	in fostering their own and their residents' well-being; and, (Detail)	2.8.e.3.	in fostering their own and their i
II.B.2.f).(4)	in patient care based on their practice-based learning and improvement efforts. (Detail)	2.8.e.4.	in patient care based on their pr improvement efforts. (Detail)
II.B.2.g)	Faculty members supervising emergency medicine residents in an adult emergency department must either be ABEM/AOBEM board-eligible or have current ABEM and/or AOBEM certification in emergency medicine. (Core)	2.8.f.	Faculty members supervising eme emergency department must eithe have current ABEM and/or AOBEN (Core)
II.B.3.	Faculty Qualifications	2.9.	Faculty Qualifications Faculty members must have app and hold appropriate institution
II.B.3.a)	Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)	2.9.	Faculty Qualifications Faculty members must have app and hold appropriate institution
II.B.3.a).(1)	Faculty members supervising emergency medicine residents on pediatric emergency medicine rotations where pediatric emergency medicine fellows are also present must be certified in pediatrics, emergency medicine, or pediatric emergency medicine by the ABEM, American Board of Pediatrics, AOBEM, or American Osteopathic Board of Pediatrics. (Core)	2.9.a.	Faculty members supervising eme emergency medicine rotations whe are also present must be certified i pediatric emergency medicine by t AOBEM, or American Osteopathic
II.B.3.a).(1).(a)	Faculty members board-certified solely in pediatrics may not supervise emergency medicine residents in the emergency department in all other settings. (Core)	2.9.a.1.	Faculty members board-certified s emergency medicine residents in t settings. (Core)
II.B.3.b)	Physician faculty members must:	[None]	
II.B.3.b).(1)	have current certification in the specialty by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine, or possess qualifications judged acceptable to the Review Committee. (Core)	2.10.	Physician faculty members mus specialty by the American Board American Osteopathic Board of qualifications judged acceptable
II.B.3.b).(2)	have certification by a subspecialty board sponsored or co-sponsored by the ABEM or the AOBEM. (Core)	2.10.a.	Physician faculty members must h sponsored or co-sponsored by the

nstrate commitment to the delivery of cost-effective, patient-centered care.

nstrate a strong interest in the education ng sufficient time to the educational sory and teaching responsibilities.

ister and maintain an educational ucating residents. (Core)

rly participate in organized clinical clubs, and conferences. (Core)

faculty development designed to

nnually: (Core)

(Detail)

nating health inequities, and patient

r residents' well-being; and, (Detail) practice-based learning and

nergency medicine residents in an adult her be ABEM/AOBEM board-eligible or EM certification in emergency medicine.

ppropriate qualifications in their field onal appointments. (Core)

ppropriate qualifications in their field onal appointments. (Core)

nergency medicine residents on pediatric where pediatric emergency medicine fellows of in pediatrics, emergency medicine, or y the ABEM, American Board of Pediatrics, nic Board of Pediatrics. (Core)

solely in pediatrics may not supervise the emergency department in all other

ust have current certification in the ard of Emergency Medicine or the of Emergency Medicine, or possess ble to the Review Committee. (Core)

have certification by a subspecialty board ne ABEM or the AOBEM. (Core)

Requirement Language	Reformatted Requirement Number	Requirem
their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)		Core Faculty Core faculty members must hav and supervision of residents and their entire effort to resident edu must, as a component of their a formative feedback to residents.
Survey. (Core)	2.11.a.	Core faculty members must con Survey. (Core)
There must be a minimum of one core physician faculty member for every three residents in the program. (Core)	2.11.b.	There must be a minimum of one of three residents in the program. (Co
At a minimum, each required core faculty member, excluding program leadership, must be provided with support equal to a dedicated minimum of 10 percent FTE for educational and administrative responsibilities that do not involve direct patient care. (Core) Assistant or associate program directors must be clinically active in	2.11.c.	At a minimum, each required core leadership, must be provided with 10 percent FTE for educational and not involve direct patient care. (Co Assistant or associate program direct
emergency medicine. (Core)	2.11.d.	emergency medicine. (Core)
Assistant or associate program directors must be core faculty members. (Core)	2.11.e.	Assistant or associate program dire
		Program Coordinator
Program Coordinator	2.12.	There must be a program coordi
There must be a program coordinator. (Core)	2.12.	Program Coordinator There must be a program coordi
The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)	2.12.a.	The program coordinator must be support adequate for administra size and configuration. (Core)
At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)		At a minimum, the program coordin dedicated time and support specifi program: (Core)
Number of Approved Resident Positions: 18-20   Minimum Support Required (FTE): 0.9 Number of Approved Resident Positions: 21-25   Minimum Support Required (FTE): 1.0 Number of Approved Resident Positions: 26-30   Minimum Support Required (FTE): 1.10 Number of Approved Resident Positions: 31-35   Minimum Support Required (FTE): 1.20 Number of Approved Resident Positions: 36-40   Minimum Support Required (FTE): 1.30		Number of Approved Resident Pos Required (FTE): 0.9 Number of Approved Resident Pos Required (FTE): 1.0 Number of Approved Resident Pos Required (FTE): 1.10 Number of Approved Resident Pos Required (FTE): 1.20 Number of Approved Resident Pos Required (FTE): 1.30
	Core Faculty         Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)         Core faculty members must complete the annual ACGME Faculty Survey. (Core)         There must be a minimum of one core physician faculty member for every three residents in the program. (Core)         At a minimum, each required core faculty member, excluding program leadership, must be provided with support equal to a dedicated minimum of 10 percent FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)         Assistant or associate program directors must be clinically active in emergency medicine. (Core)         Assistant or associate program directors must be core faculty members. (Core)         Program Coordinator         There must be a program coordinator. (Core)         The program coordinator must be provided with the dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)         At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)         Number of Approved Resident Positions: 18-20   Minimum Support Required (FTE): 0.9         Number of Approved Resident Positions: 26-30   Minimum Support Required (FTE): 1.10         Number of Approved Resident Positions: 31-35   Minimum Support Required (FTE): 1.	Core Faculty         Core Faculty           Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)         2.11.           Core faculty members must complete the annual ACGME Faculty Survey. (Core)         2.11.a.           There must be a minimum of one core physician faculty member for every three residents in the program. (Core)         2.11.b.           At a minimum, each required core faculty member, excluding program leadership, must be provided with support equal to a dedicated minimum of 10 percent FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)         2.11.c.           Assistant or associate program directors must be cinically active in emergency medicine. (Core)         2.11.d.           Assistant or associate program directors must be core faculty members. (Core)         2.11.e.           Program Coordinator         2.12.           There must be a program coordinator. (Core)         2.12.           There program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)         2.12.a.           At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)         2.12.a.           Number of Approved Resident Pos

#### ment Language

ave a significant role in the education and must devote a significant portion of ducation and/or administration, and activities, teach, evaluate, and provide ts. (Core)

mplete the annual ACGME Faculty

e core physician faculty member for every Core)

e faculty member, excluding program h support equal to a dedicated minimum of and administrative responsibilities that do Core)

lirectors must be clinically active in

lirectors must be core faculty members.

#### dinator. (Core)

#### dinator. (Core)

t be provided with dedicated time and ration of the program based upon its

dinator must be provided with the ified below for administration of the

ositions: 18-20 | Minimum Support

ositions: 21-25 | Minimum Support

ositions: 26-30 | Minimum Support

ositions: 31-35 | Minimum Support

ositions: 36-40 | Minimum Support

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
	Number of Approved Resident Positions: 41-45   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 1.40		Required (FTE): 1.40
	Number of Approved Resident Positions: 46-50   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 1.50		Required (FTE): 1.50
	Number of Approved Resident Positions: 51-55   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 1.60		Required (FTE): 1.60
	Number of Approved Resident Positions: 56-60   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 1.70		Required (FTE): 1.70
	Number of Approved Resident Positions: 61-65   Minimum Support Required (FTE): 1.80		Number of Approved Resident Pos Required (FTE): 1.80
	Number of Approved Resident Positions: 66-70   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 1.90		Required (FTE): 1.90
	Number of Approved Resident Positions: 71-75   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 2.0		Required (FTE): 2.0
	Number of Approved Resident Positions: 76-80   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 2.10		Required (FTE): 2.10
	Number of Approved Resident Positions: 81-85   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 2.20		Required (FTE): 2.20
	Number of Approved Resident Positions: 86-90   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 2.30		Required (FTE): 2.30
	Number of Approved Resident Positions: 91-95   Minimum Support		Number of Approved Resident Pos
	Required (FTE): 2.40		Required (FTE): 2.40
ILC 2 c) (Continued)	Number of Approved Resident Positions: 96-100   Minimum Support	2.12 h (Continued)	Number of Approved Resident Pos
II.C.2.a) - (Continued)	Required (FTE): 2.50	2.12.b (Continued)	Required (FTE): 2.50
	Other Program Personnel		Other Program Personnel
	The program, in partnership with its Sponsoring Institution, must		The program, in partnership with
	jointly ensure the availability of necessary personnel for the effective		jointly ensure the availability of
II.D.	administration of the program. (Core)	2.13.	administration of the program. (
III.	Resident Appointments	Section 3	Section 3: Resident Appointmen
			Eligibility Requirements
			An applicant must meet one of t
II.A.	Eligibility Requirements	3.2.	eligible for appointment to an AC
			Eligibility Requirements
	An applicant must meet one of the following qualifications to be		An applicant must meet one of the
III.A.1.	eligible for appointment to an ACGME-accredited program: (Core)	3.2.	eligible for appointment to an AC
	graduation from a medical school in the United States, accredited by		graduation from a medical schoo
	the Liaison Committee on Medical Education (LCME) or graduation		the Liaison Committee on Medic
	from a college of osteopathic medicine in the United States,		from a college of osteopathic me
	accredited by the American Osteopathic Association Commission on		accredited by the American Oste
III.A.1.a)	Osteopathic College Accreditation (AOACOCA); or, (Core)	3.2.a.	Osteopathic College Accreditation

- ositions: 41-45 | Minimum Support
- ositions: 46-50 | Minimum Support
- ositions: 51-55 | Minimum Support
- ositions: 56-60 | Minimum Support
- ositions: 61-65 | Minimum Support
- ositions: 66-70 | Minimum Support
- ositions: 71-75 | Minimum Support
- ositions: 76-80 | Minimum Support
- ositions: 81-85 | Minimum Support
- ositions: 86-90 | Minimum Support
- ositions: 91-95 | Minimum Support
- ositions: 96-100 | Minimum Support

ith its Sponsoring Institution, must of necessary personnel for the effective (Core) ents

f the following qualifications to be ACGME-accredited program: (Core)

f the following qualifications to be ACGME-accredited program: (Core)

ool in the United States, accredited by ical Education (LCME) or graduation nedicine in the United States, steopathic Association Commission on tion (AOACOCA); or, (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
			graduation from a medical scho meeting one of the following ad
			<ul> <li>holding a currently valid certifi</li> <li>Commission for Foreign Medica</li> <li>appointment; or, (Core)</li> </ul>
III.A.1.b)	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)	3.2.b.	<ul> <li>holding a full and unrestricted United States licensing jurisdict program is located. (Core)</li> </ul>
			graduation from a medical scho meeting one of the following ad
			<ul> <li>holding a currently valid certifi</li> <li>Commission for Foreign Medica</li> <li>appointment; or, (Core)</li> </ul>
III.A.1.b).(1)	holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)	3.2.b.	<ul> <li>holding a full and unrestricted United States licensing jurisdict program is located. (Core)</li> </ul>
			graduation from a medical scho meeting one of the following add
			<ul> <li>holding a currently valid certifi</li> <li>Commission for Foreign Medica</li> <li>appointment; or, (Core)</li> </ul>
III.A.1.b).(2)	holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)	3.2.b.	<ul> <li>holding a full and unrestricted</li> <li>United States licensing jurisdict</li> <li>program is located. (Core)</li> </ul>
III.A.2.	All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA- approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)	3.3.	All prerequisite post-graduate cl entry or transfer into ACGME-ac completed in ACGME-accredited residency programs, Royal Colle Canada (RCPSC)-accredited or C Canada (CFPC)-accredited resid in residency programs with ACC Advanced Specialty Accreditation
III.A.2.a)	Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)	3.3.a.	Residency programs must recei of competency in the required c or ACGME-I Milestones evaluation upon matriculation. (Core)
III.A.2.a)	Resident Complement	5.5.a.	
III.B.	The program director must not appoint more residents than approved by the Review Committee. (Core)	3.4.	Resident Complement The program director must not a by the Review Committee. (Core
III.B.1.	There should be a total of at least 18 residents in the program. (Core)	3.4.a.	There should be a total of at least

nool outside of the United States, and additional qualifications: (Core)

ificate from the Educational cal Graduates (ECFMG) prior to

ed license to practice medicine in the iction in which the ACGME-accredited

nool outside of the United States, and additional qualifications: (Core)

tificate from the Educational cal Graduates (ECFMG) prior to

ed license to practice medicine in the iction in which the ACGME-accredited

nool outside of the United States, and additional qualifications: (Core)

ificate from the Educational cal Graduates (ECFMG) prior to

ed license to practice medicine in the iction in which the ACGME-accredited

clinical education required for initial accredited residency programs must be ted residency programs, AOA-approved ollege of Physicians and Surgeons of or College of Family Physicians of sidency programs located in Canada, or CGME International (ACGME-I) ition. (Core)

eive verification of each resident's level clinical field using ACGME, CanMEDS, ations from the prior training program

t appoint more residents than approved re)

st 18 residents in the program. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
III.C.	Resident Transfers The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)	3.5.	Resident Transfers The program must obtain verific experiences and a summative c evaluation prior to acceptance of Milestones evaluations upon ma
III.C.1.	For information concerning the transfer of residents between emergency medicine residencies with differing educational formats and advanced placement credit for education in other specialties, contact the ABEM and/or the AOBEM prior to the resident entering the program.	3.5.a.	For information concerning the train medicine residencies with differing placement credit for education in c and/or the AOBEM prior to the res
	Educational Program The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless		Section 4: Educational Program The ACGME accreditation system excellence and innovation in grad
	of the organizational affiliation, size, or location of the program. The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care. It is recognized programs may place different emphasis on research,		of the organizational affiliation, s The educational program must s knowledgeable, skillful physicia It is recognized programs may p
IV.	leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.	Section 4	leadership, public health, etc. It will reflect the nuanced program graduates; for example, it is exp prepare physician-scientists wil focusing on community health.
IV.A.	Educational Components The curriculum must contain the following educational components:	4.2.	Educational Components The curriculum must contain the
IV.A.1.	a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)	4.2.a.	a set of program aims consisten mission, the needs of the comm distinctive capabilities of its gra available to program applicants, (Core)
IV.A.2.	competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)	4.2.b.	competency-based goals and ob experience designed to promote autonomous practice. These mu available to residents and facult
IV.A.3.	delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)	4.2.c.	delineation of resident responsi responsibility for patient manag (Core)
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured dida
IV.A.4.a)	Residents must be provided with protected time to participate in core didactic activities. (Core)	4.11.	Curriculum Organization and Re Clinical Experiences Residents must be provided with didactic activities. (Core)

ication of previous educational competency-based performance of a transferring resident, and natriculation. (Core)

ansfer of residents between emergency ng educational formats and advanced other specialties, contact the ABEM esident entering the program.

#### m

tem is designed to encourage raduate medical education regardless , size, or location of the program.

t support the development of ians who provide compassionate care.

place different emphasis on research, It is expected that the program aims m-specific goals for it and its expected that a program aiming to vill have a different curriculum from one

he following educational components:

ent with the Sponsoring Institution's munity it serves, and the desired raduates, which must be made s, residents, and faculty members;

objectives for each educational te progress on a trajectory to nust be distributed, reviewed, and Ilty members; (Core)

sibilities for patient care, progressive gement, and graded supervision;

dactic activities; and, (Core) Resident Experiences – Didactic and

ith protected time to participate in core

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
IV.A.5.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)	4.2.e.	formal educational activities tha goals, tools, and techniques. (Co
IV.B.	ACGME Competencies	[None]	ACGME Competencies The Competencies provide a con required domains for a trusted p practice. These Competencies a physicians, although the specifi specialty. The developmental tra Competencies are articulated th specialty.
	The program must integrate the following ACGME Competencies		The program must integrate all A
IV.B.1.	into the curriculum:	[None]	curriculum.
	Professionalism		ACGME Competencies – Profess Residents must demonstrate a c an adherence to ethical principle
IV.B.1.a)	Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)	4.3.	Residents must demonstrate co
			ACGME Competencies – Profess Residents must demonstrate a c an adherence to ethical principle
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	Residents must demonstrate co
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)	4.3.a.	compassion, integrity, and respe
IV.B.1.a).(1).(b)	responsiveness to patient needs that supersedes self-interest; (Core)	4.3.b.	responsiveness to patient needs
IV.B.1.a).(1).(c)	cultural humility; (Core)	4.3.c.	cultural humility; (Core)
IV.B.1.a).(1).(d)	respect for patient privacy and autonomy; (Core)	4.3.d.	respect for patient privacy and a
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)	4.3.e.	accountability to patients, societ
IV.B.1.a).(1).(f)	respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)	4.3.f.	respect and responsiveness to c but not limited to diversity in gen disabilities, national origin, socio orientation; (Core)
IV.B.1.a).(1).(g)	ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)	4.3.g.	ability to recognize and develop professional well-being; and, (Co
IV.B.1.a).(1).(h)	appropriately disclosing and addressing conflict or duality of interest. (Core)	4.3.h.	appropriately disclosing and add (Core)
IV.B.1.b)	Patient Care and Procedural Skills	[None]	
IV.B.1.b).(1)	Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)	4.4.	ACGME Competencies – Patient Residents must be able to provid family-centered, compassionate for the treatment of health proble (Core)
	Residents must demonstrate competence in:	[None]	

nat promote patient safety-related Core)

conceptual framework describing the I physician to enter autonomous are core to the practice of all ifics are further defined by each trajectories in each of the through the Milestones for each

ACGME Competencies into the

essionalism a commitment to professionalism and ples. (Core)

competence in:

essionalism a commitment to professionalism and ples. (Core)

competence in: pect for others; (Core)

ds that supersedes self-interest; (Core)

autonomy; (Core)

iety, and the profession; (Core)

o diverse patient populations, including lender, age, culture, race, religion, cioeconomic status, and sexual

op a plan for one's own personal and Core)

ddressing conflict or duality of interest.

nt Care

vide patient care that is patient- and te, equitable, appropriate, and effective blems and the promotion of health.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
IV.B.1.b).(1).(a).(i)	synthesizing essential data necessary for the correct management of a patient with multiple chronic medical problems and, when appropriate, comparing with a prior medical record and identifying significant differences between the current presentation and past presentations; (Core)	4.4.a.	Residents must demonstrate comp necessary for the correct manager medical problems and, when appro record and identifying significant d presentation and past presentation
IV.B.1.b).(1).(a).(ii)	generating an appropriate differential diagnosis; (Core)	4.4.b.	Residents must demonstrate comp differential diagnosis. (Core)
IV.B.1.b).(1).(a).(iii)	applying the results of diagnostic testing based on the probability of disease and the likelihood of test results altering management; (Core)	4.4.c.	Residents must demonstrate comp diagnostic testing based on the pro- test results altering management.
IV.B.1.b).(1).(a).(iv)	narrowing and prioritizing the list of weighted differential diagnoses to determine appropriate management based on all of the available data; (Core)	4.4.d.	Residents must demonstrate comp list of weighted differential diagnos management based on all of the a
IV.B.1.b).(1).(a).(v)	implementing an effective patient management plan; (Core)	4.4.e.	Residents must demonstrate comp patient management plan. (Core)
IV.B.1.b).(1).(a).(vi)	selecting and prescribing appropriate pharmaceutical agents based upon relevant considerations, such as: allergies; clinical guidelines; intended effect; financial considerations; institutional policies; mechanism of action; patient preferences; possible adverse effects; and potential drug-food and drug-drug interactions; and effectively combining agents and monitoring and intervening in the advent of adverse effects in the emergency department; (Core)		Residents must demonstrate comp appropriate pharmaceutical agents such as: allergies; clinical guidelin- considerations; institutional policie preferences; possible adverse effe drug interactions; and effectively c intervening in the advent of advers (Core)
IV.B.1.b).(1).(a).(vii)	progressing along a continuum of managing a single patient, to managing multiple patients and resources within the emergency department; (Core)	4.4.g.	Residents must demonstrate comp continuum of managing a single pa resources within the emergency de
IV.B.1.b).(1).(a).(viii)	providing health care services aimed at preventing health problems or maintaining health; (Core)	4.4.h.	Residents must demonstrate comp aimed at preventing health probler
IV.B.1.b).(1).(a).(ix)	working with health care professionals to provide patient-focused care; (Core)	4.4.i.	Residents must demonstrate comp professionals to provide patient-foo
IV.B.1.b).(1).(a).(x)	identifying life-threatening conditions and the most likely diagnosis, synthesizing acquired patient data, and identifying how and when to access current medical information; (Core)	4.4.j.	Residents must demonstrate comp conditions and the most likely diag data, and identifying how and when (Core)
IV.B.1.b).(1).(a).(xi)	establishing and implementing a comprehensive disposition plan that uses appropriate consultation resources, patient education regarding diagnosis, treatment plan, medications, and time and location specific disposition instructions; and, (Core)		Residents must demonstrate comp a comprehensive disposition plan t resources, patient education regar medications, and time and location
IV.B.1.b).(1).(a).(xii)	re-evaluating patients undergoing emergency department observation (and monitoring) and using appropriate data and resources, and, determining the differential diagnosis, treatment plan, and disposition. (Core)	4.4.1.	Residents must demonstrate comp undergoing emergency departmen appropriate data and resources, an treatment plan, and disposition. (C
IV.B.1.b).(2)	Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)	4.5.	ACGME Competencies – Proced able to perform all medical, diag considered essential for the area

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npetence in synthesizing essential data ement of a patient with multiple chronic propriate, comparing with a prior medical differences between the current ons. (Core)

npetence in generating an appropriate

npetence in applying the results of probability of disease and the likelihood of ... (Core)

npetence in narrowing and prioritizing the oses to determine appropriate available data. (Core)

npetence in implementing an effective )

npetence in selecting and prescribing nts based upon relevant considerations, nes; intended effect; financial ies; mechanism of action; patient fects; and potential drug-food and drugcombining agents and monitoring and rse effects in the emergency department.

npetence in progressing along a patient, to managing multiple patients and department. (Core)

npetence in providing health care services ems or maintaining health. (Core)

npetence in working with health care occused care. (Core)

npetence in identifying life-threatening agnosis, synthesizing acquired patient ien to access current medical information.

npetence in establishing and implementing n that uses appropriate consultation arding diagnosis, treatment plan, on specific disposition instructions. (Core)

npetence in re-evaluating patients ent observation (and monitoring) and using and, determining the differential diagnosis, Core)

edural Skills: Residents must be agnostic, and surgical procedures rea of practice. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
IV.B.1.b).(2).(a)	Residents must demonstrate competence in:	[None]	
IV.B.1.b).(2).(a).(i)	performing diagnostic and therapeutic procedures and emergency stabilization; (Core)	4.5.a.	Residents must demonstrate comp therapeutic procedures and emerge
IV.B.1.b).(2).(a).(ii)	managing critically ill and injured patients who present to the emergency department, prioritizing critical initial stabilization action, mobilizing hospital support services in the resuscitation of critically-ill or injured patients and reassessing after a stabilizing intervention; (Core)	4.5.b.	Residents must demonstrate comp injured patients who present to the critical initial stabilization action, mo resuscitation of critically-ill or injure stabilizing intervention. (Core)
IV.B.1.b).(2).(a).(iii)	properly sequencing critical actions for patient care and generating a differential diagnosis for an undifferentiated patient; (Core)	4.5.c.	Residents must demonstrate comp actions for patient care and genera undifferentiated patient. (Core)
IV.B.1.b).(2).(a).(iv)	mobilizing and managing necessary personnel and other hospital resources to meet critical needs of multiple patients; and, (Core)	4.5.d.	Residents must demonstrate comp necessary personnel and other hos multiple patients. (Core)
IV.B.1.b).(2).(a).(v)	performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types on all age groups. (Core)	4.5.e.	Residents must demonstrate comp procedures, monitoring unstable pa resuscitations of all types on all age
IV.B.1.b).(2).(b)	Residents must perform indicated procedures on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation, take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)	4.5.f.	Residents must perform indicated p including those who are uncoopera hemodynamically unstable and who defined anatomy, high risk for pain sedation, take steps to avoid poten outcome and/or complications resu
IV.B.1.b).(2).(c)	Residents must demonstrate competence in performing the following key index procedures:	4.5.g.	Residents must demonstrate comp index procedures:
IV.B.1.b).(2).(c).(i)	adult medical resuscitation; (Core)	4.5.g.1.	adult medical resuscitation; (Core)
IV.B.1.b).(2).(c).(ii)	adult trauma resuscitation; (Core)	4.5.g.2.	adult trauma resuscitation; (Core)
IV.B.1.b).(2).(c).(iii)	anesthesia and pain management; (Core)	4.5.g.3.	anesthesia and pain management;
IV.B.1.b).(2).(c).(iii).(a)	Residents must provide safe acute pain management, anesthesia, and procedural sedation to patients of all ages regardless of the clinical situation. (Core)	4.5.g.3.a.	Residents must provide safe acute procedural sedation to patients of a situation. (Core)
IV.B.1.b).(2).(c).(iv)	cardiac pacing; (Core)	4.5.g.4.	cardiac pacing; (Core)
IV.B.1.b).(2).(c).(v)	chest tubes; (Core)	4.5.g.5.	chest tubes; (Core)
IV.B.1.b).(2).(c).(vi)	cricothyrotomy; (Core)	4.5.g.6.	cricothyrotomy; (Core)
IV.B.1.b).(2).(c).(vii)	dislocation reduction; (Core)	4.5.g.7.	dislocation reduction; (Core)
IV.B.1.b).(2).(c).(viii)	emergency department bedside ultrasound; (Core)	4.5.g.8.	emergency department bedside ult
IV.B.1.b).(2).(c).(viii).(a)	Residents must use ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance. (Core)	4.5.g.8.a.	Residents must use ultrasound for emergency medical conditions and ill or injured patient, and procedura
IV.B.1.b).(2).(c).(ix)	intubations; (Core)	4.5.g.9.	intubations; (Core)

npetence in performing diagnostic and rgency stabilization. (Core)

npetence in managing critically ill and ne emergency department, prioritizing mobilizing hospital support services in the ured patients and reassessing after a

npetence in properly sequencing critical rating a differential diagnosis for an

npetence in mobilizing and managing ospital resources to meet critical needs of

npetence in performing invasive patients, and directing major age groups. (Core)

d procedures on all appropriate patients, erative, at the extremes of age, who have multiple co-morbidities, poorly in or procedural complications, or require ential complications; and recognize the esulting from the procedures. (Core) mpetence in performing the following key

nt; (Core)

te pain management, anesthesia, and f all ages regardless of the clinical

#### ultrasound; (Core)

or the bedside diagnostic evaluation of nd diagnoses, resuscitation of the acutely ral guidance. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
	Residents must perform airway management on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation); take steps to avoid potential complications; and recognize the		Residents must perform airway ma including those who are uncoopera hemodynamically unstable and wh defined anatomy, high risk for pain sedation); take steps to avoid pote
IV.B.1.b).(2).(c).(ix).(a)	outcome and/or complications resulting from the procedures. (Core)	4.5.g.9.a.	outcome and/or complications resu
IV.B.1.b).(2).(c).(x)	lumbar puncture; (Core)	4.5.g.10.	lumbar puncture; (Core)
IV.B.1.b).(2).(c).(xi)	pediatric medical resuscitation; (Core)	4.5.g.11.	pediatric medical resuscitation; (Co
IV.B.1.b).(2).(c).(xii)	pediatric trauma resuscitation; (Core)	4.5.g.12.	pediatric trauma resuscitation; (Co
IV.B.1.b).(2).(c).(xiii)	pericardiocentesis; (Core)	4.5.g.13.	pericardiocentesis; (Core)
IV.B.1.b).(2).(c).(xiv)	procedural sedation; (Core)	4.5.g.14.	procedural sedation; (Core)
IV.B.1.b).(2).(c).(xv)	vaginal delivery; (Core)	4.5.g.15.	vaginal delivery; (Core)
IV.B.1.b).(2).(c).(xvi)	vascular access; and, (Core)	4.5.g.16.	vascular access; and, (Core)
IV.B.1.b).(2).(c).(xvi).(a)	Residents must successfully obtain vascular access in patients of all ages regardless of the clinical situation. (Core)	4.5.g.16.a.	Residents must successfully obtain regardless of the clinical situation.
IV.B.1.b).(2).(c).(xvii)	wound management. (Core)	4.5.g.17.	wound management. (Core)
IV.B.1.b).(2).(c).(xvii).(a)	Residents must assess and appropriately manage wounds in patients of all ages regardless of the clinical situation. (Core)	4.5.g.17.a.	Residents must assess and approp ages regardless of the clinical situa
IV.B.1.c)	Medical Knowledge Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)		ACGME Competencies – Medica Residents must demonstrate kno biomedical, clinical, epidemiolog including scientific inquiry, as w knowledge to patient care. (Core
IV.B.1.c).(1)	Residents must demonstrate appropriate medical knowledge in the care of emergency medicine patients; and, (Core)	4.6.a.	Residents must demonstrate appro emergency medicine patients; and,
IV.B.1.c).(2)	Residents must demonstrate knowledge of the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values. (Core)	4.6.b.	Residents must demonstrate know problem solving, evidence-based d lifelong learning, and an attitude of professional values. (Core)
IV.B.1.d)	Practice-based Learning and Improvement Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self- evaluation and lifelong learning; (Core)	4.7.	ACGME Competencies – Practice Residents must demonstrate the their care of patients, to appraise and to continuously improve pat evaluation and lifelong learning.
IV.B.1.d).(1)	Residents must demonstrate competence in:	[None]	
IV.B.1.d).(1).(a)	identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)	4.7.a.	Residents must demonstrate con deficiencies, and limits in one's
IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)	4.7.b.	Residents must demonstrate con improvement goals. (Core)
IV.B.1.d).(1).(c)	identifying and performing appropriate learning activities; (Core)	4.7.c.	Residents must demonstrate con performing appropriate learning

nanagement on all appropriate patients, erative, at the extremes of age,

who have multiple co-morbidities, poorly in or procedural complications, or require tential complications; and recognize the sulting from the procedures. (Core)

Core) Core)

ain vascular access in patients of all ages n. (Core)

opriately manage wounds in patients of all tuation. (Core)

#### cal Knowledge

nowledge of established and evolving ogical, and social-behavioral sciences, well as the application of this re)

propriate medical knowledge in the care of nd, (Core)

owledge of the scientific method of d decision making, a commitment to of caring derived from humanistic and

ice-Based Learning and Improvement he ability to investigate and evaluate ise and assimilate scientific evidence, patient care based on constant selfg. (Core)

competence in identifying strengths, s knowledge and expertise. (Core) competence in setting learning and

competence in identifying and ng activities. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
	systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice		Residents must demonstrate co practice using quality improvem aimed at reducing health care di
IV.B.1.d).(1).(d)	improvement; (Core)	4.7.d.	with the goal of practice improve
IV.B.1.d).(1).(e)	incorporating feedback and formative evaluation into daily practice; and, (Core)	4.7.e.	Residents must demonstrate co and formative evaluation into da
IV.B.1.d).(1).(f)	locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)	4.7.f.	Residents must demonstrate co assimilating evidence from scien health problems. (Core)
IV.B.1.d).(1).(g)	applying knowledge of study design and statistical methods to critically appraise the medical literature; (Core)	4.7.g.	Residents must demonstrate comp design and statistical methods to c (Core)
			Residents must demonstrate comp
IV.B.1.d).(1).(h)	using information technology to improve patient care; (Core)	4.7.h.	to improve patient care. <sup>(Core)</sup>
IV.B.1.d).(1).(i)	evaluating teaching effectiveness; and, (Core)	4.7.i.	Residents must demonstrate comp effectiveness. (Core)
IV.B.1.d).(1).(j)	teaching different audiences using appropriate strategies based on targeted learning objectives. (Core)	4.7.j.	Residents must demonstrate compusing appropriate strategies based
IV.B.1.e)	Interpersonal and Communication Skills Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)		ACGME Competencies – Interpe Residents must demonstrate int that result in the effective excha with patients, their families, and
IV.B.1.e).(1)	Residents must demonstrate competence in	[None]	
IV.B.1.e).(1).(a)	communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)	4.8.a.	Residents must demonstrate co effectively with patients and pat a broad range of socioeconomic backgrounds, and language cap interpretive services as required patient. <sup>(Core)</sup>
IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; (Core)	4.8.b.	Residents must demonstrate co effectively with physicians, othe related agencies. (Core)
IV.B.1.e).(1).(c)	working effectively as a member or leader of a health care team or other professional group; (Core)	4.8.c.	Residents must demonstrate co member or leader of a health ca (Core)
IV.B.1.e).(1).(d)	educating patients, patients' families, students, other residents, and other health professionals; (Core)	4.8.d.	Residents must demonstrate co patients' families, students, othe professionals. (Core)
IV.B.1.e).(1).(e)	acting in a consultative role to other physicians and health professionals; (Core)	4.8.e.	Residents must demonstrate co role to other physicians and hea
IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible health care records, if applicable. (Core)	4.8.f.	Residents must demonstrate co comprehensive, timely, and legi (Core)
IV.B.1.e).(1).(g)	communicating sensitive issues or unexpected outcomes, including: (Core)	4.8.h.	Residents must demonstrate comp issues or unexpected outcomes, ir
IV.B.1.e).(1).(g).(i)	diagnostic findings; (Core)	4.8.h.1.	diagnostic findings; (Core)

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competence in systematically analyzing ement methods, including activities disparities, and implementing changes ovement. (Core)

competence in incorporating feedback daily practice. (Core)

competence in locating, appraising, and ientific studies related to their patients'

npetence in applying knowledge of study oritically appraise the medical literature.

mpetence in using information technology

npetence in evaluating teaching

mpetence in teaching different audiences ed on targeted learning objectives. (Core)

Dersonal and Communication Skills Interpersonal and communication skills Inange of information and collaboration Ind health professionals. (Core)

competence in communicating atients' families, as appropriate, across nic circumstances, cultural apabilities, learning to engage red to provide appropriate care to each

competence in communicating her health professionals, and health-

competence in working effectively as a care team or other professional group.

competence in educating patients, ther residents, and other health

competence in acting in a consultative ealth professionals. (Core)

competence in maintaining gible health care records, if applicable.

npetence in communicating sensitive including: (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
IV.B.1.e).(1).(g).(ii)	end-of-life issues and death; and, (Core)	4.8.h.2.	end-of-life issues and death; and,
IV.B.1.e).(1).(g).(iii)	medical errors. (Core)	4.8.h.3.	medical errors. (Core)
IV.B.1.e).(1).(h)	leading patient care teams, ensuring effective communication and mutual respect among team members. (Core)	4.8.i.	Residents must demonstrate comp ensuring effective communication members. (Core)
IV.B.1.e).(2)	Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)	4.8.g.	Residents must learn to commu families to partner with them to when appropriate, end-of-life go
IV.B.1.f).	Systems-based Practice Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)	4.9.	ACGME Competencies - System Residents must demonstrate an the larger context and system of and social determinants of healt effectively on other resources to
IV.B.1.f).(1)	Residents must demonstrate competence in:	[None]	
IV.B.1.f).(1).(a)	working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)	4.9.a.	Residents must demonstrate co various health care delivery sett clinical specialty. <sup>(Core)</sup>
IV.B.1.f).(1).(b)	coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)	4.9.b.	Residents must demonstrate co across the health care continuu clinical specialty. <sup>(Core)</sup>
IV.B.1.f).(1).(c)	advocating for quality patient care and optimal patient care systems; (Core)	4.9.c.	Residents must demonstrate co patient care and optimal patient
IV.B.1.f).(1).(d)	participating in identifying system errors and implementing potential systems solutions; (Core)	4.9.d.	Residents must demonstrate co identifying system errors and im solutions. (Core)
IV.B.1.f).(1).(e)	incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;(Core)	4.9.e.	Residents must demonstrate co considerations of value, equity, payment, and risk-benefit analys care as appropriate. (Core)
IV.B.1.f).(1).(f)	understanding health care finances and its impact on individual patients' health decisions; and, (Core)	4.9.f.	Residents must demonstrate co care finances and its impact on (Core)
IV.B.1.f).(1).(g)	using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)	4.9.g.	Residents must demonstrate co techniques that promote patient safety events (real or simulated)
IV.B.1.f).(1).(h)	participation in performance improvement to optimize self-learning, emergency department function, and patient safety; and, (Core)	4.9.i.	Residents must demonstrate comp improvement to optimize self-learn and patient safety. (Core)
IV.B.1.f).(1).(i)	using technology to accomplish and document safe health care delivery. (Core)	4.9.j.	Residents must demonstrate comp accomplish and document safe he
IV.B.1.f).(2)	Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)	4.9.h.	Residents must learn to advocat system to achieve the patient's a including, when appropriate, en

, (Core)

mpetence in leading patient care teams, on and mutual respect among team

nunicate with patients and patients' to assess their care goals, including, goals. (Core)

ms-Based Practice

an awareness of and responsiveness to of health care, including the structural alth, as well as the ability to call to provide optimal health care. (Core)

competence in working effectively in ettings and systems relevant to their

competence in coordinating patient care uum and beyond as relevant to their

competence in advocating for quality nt care systems. (Core)

competence in participating in implementing potential systems

competence in incorporating y, cost awareness, delivery and lysis in patient and/or population-based

competence in understanding health on individual patients' health decisions.

competence in using tools and ent safety and disclosure of patient ed). (Detail)

mpetence in participation in performance rning, emergency department function,

npetence in using technology to nealth care delivery. (Core)

cate for patients within the health care s and patient's family's care goals, end-of-life goals. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
			4.10. Curriculum Organization an Curriculum Structure The curriculum must be structur experiences, the length of the ex continuity. These educational ex blend of supervised patient care and didactic educational events
			4.11. Curriculum Organization an and Clinical Experiences Residents must be provided with didactic activities. (Core)
IV.C.	Curriculum Organization and Resident Experiences	4.10 4.12.	4.12. Curriculum Organization an Management The program must provide instr management if applicable for the the signs of substance use diso
IV.C.1.	The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)	4.10.	Curriculum Organization and Re Structure The curriculum must be structur experiences, the length of the ex continuity. These educational ex blend of supervised patient care and didactic educational events.
IV.C.1.a)	Clinical experiences should be structured to facilitate learning in a manner that allows the residents to function as part of an effective interprofessional team that works together toward the shared goals of patient safety and quality improvement. (Detail)	4.10.a.	Clinical experiences should be stru that allows the residents to function team that works together toward the quality improvement. (Detail)
IV.C.1.a).(1)	The emergency medicine program director is responsible for determining the duration of the clinical experiences for the emergency medicine residents on all rotations. (Core)	4.10.b.	The emergency medicine program the duration of the clinical experier residents on all rotations. (Core)
IV.C.2.	The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)	4.12.	Curriculum Organization and Re Management: The program must in pain management if applicable recognition of the signs of subst
IV.C.3.	Didactics	4.11.a.	Didactics Didactic experiences must include presentations based on the defined conferences, and research semina
IV.C.3.a)	Didactic experiences must include administrative seminars, journal review, presentations based on the defined curriculum, morbidity and mortality conferences, and research seminars. (Core)	4.11.a.	Didactics Didactic experiences must include presentations based on the defined conferences, and research semina
IV.C.3.a).(1)	These didactic experiences should include joint conferences co- sponsored with other disciplines. (Core)	4.11.a.1.	These didactic experiences should with other disciplines. (Core)

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and Resident Experiences –
ured to optimize resident educational experiences, and the supervisory experiences include an appropriate re responsibilities, clinical teaching, s. (Core)
and Resident Experiences – Didactic
th protected time to participate in core
and Resident Experiences – Pain
ruction and experience in pain he specialty, including recognition of order. (Core)
esident Experiences – Curriculum
ured to optimize resident educational experiences, and the supervisory experiences include an appropriate re responsibilities, clinical teaching, s. (Core)
ructured to facilitate learning in a manner on as part of an effective interprofessional the shared goals of patient safety and
n director is responsible for determining ences for the emergency medicine
tesident Experiences – Pain st provide instruction and experience ble for the specialty, including stance use disorder. (Core)
e administrative seminars, journal review, ed curriculum, morbidity and mortality nars. (Core)
e administrative seminars, journal review, ed curriculum, morbidity and mortality ars. (Core)
Id include joint conferences co-sponsored

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
IV.C.3.a).(2)	Educational methods should include problem-based learning, evidence- based learning, and computer-based instruction. (Core)	4.11.a.2.	Educational methods should includ based learning, and computer-bas
IV.C.3.b)	The majority of didactic experiences must occur at the primary clinical site. (Core)	4.11.a.3.	The majority of didactic experience (Core)
IV.C.3.c)	There must be an average of at least five hours per week of planned didactic experiences developed by the program's faculty members. (Core)	4.11.a.4.	There must be an average of at lea didactic experiences developed by
IV.C.3.c).(1)	Individualized interactive instruction must not exceed 20 percent of the planned didactic experiences. (Core)	4.11.a.5.	Individualized interactive instructio planned didactic experiences. (Col
IV.C.3.c).(2)	All planned didactic experiences must be supervised by core physician faculty members. (Core)	4.11.a.6.	All planned didactic experiences m faculty members. (Core)
IV.C.3.c).(3)	Each core physician faculty member must attend, on average per year, at least 20 percent of planned didactic experiences. (Core)	4.11.a.7.	Each core physician faculty memb least 20 percent of planned didacti
IV.C.3.c).(4)	Emergency medicine faculty members must present at least 50 percent of resident conferences. (Core)	4.11.a.8.	Emergency medicine faculty membresident conferences. (Core)
IV.C.3.c).(5)	Residents must actively participate, on average, in at least 70 percent of the planned didactic experiences offered. (Core)	4.11.a.9.	Residents must actively participate the planned didactic experiences of
I.A.1.a).(1)	All planned didactic experiences must have an evaluative component to measure resident participation and educational effectiveness. (Core)	4.11.a.10.	All planned didactic experiences m measure resident participation and
IV.C.4.	Curriculum The curriculum must include:	4.11.b.	Curriculum The curriculum must include four n experiences, including critical care
IV.C.4.a)	four months of dedicated critical care experiences, including critical care of infants and children; (Core)	4.11.b.	Curriculum The curriculum must include four n experiences, including critical care
IV.C.4.a).(1)	At least two months of these experiences must be at the PGY-2 level or above. (Core)	4.11.b.1.	At least two months of these exper above. (Core)
IV.C.4.b)	five FTE months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department or other pediatric settings; (Core)	4.11.c.	The curriculum must include five F emergency department encounters patients less than 18 years of age or other pediatric settings. (Core)
IV.C.4.b).(1)	At least 50 percent of the five months should be in an emergency setting. (Core)	4.11.c.1.	At least 50 percent of the five mon (Core)
IV.C.4.b).(2)	This experience must include the critical care of infants and children. (Core)	4.11.c.2.	This experience must include the c (Core)
IV.C.4.c)	at least 10 low-risk normal spontaneous vaginal deliveries; and, (Core)	4.11.d.	The curriculum must include at lea vaginal deliveries. (Core)
IV.C.4.d)	at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in the emergency department under the supervision of emergency medicine faculty members. (Core)	4.11.e.	The curriculum must include at lea experience, including experiences patients less than 18 years of age must take place in the emergency emergency medicine faculty memb
IV.C.4.d).(1)	Residents should treat a significant number of critically ill or critically injured patients at participating sites. (Core)	4.11.e.1.	Residents should treat a significan injured patients at participating site
IV.C.4.d).(1).(a)	These patients should be those admitted to intensive care units, operative care, or the morgue following treatment in the emergency department. (Core)		These patients should be those ad care, or the morgue following treat (Core)

#### ement Language

ude problem-based learning, evidenceased instruction. (Core)

ces must occur at the primary clinical site.

least five hours per week of planned by the program's faculty members. (Core)

tion must not exceed 20 percent of the Core)

must be supervised by core physician

nber must attend, on average per year, at ctic experiences. (Core)

mbers must present at least 50 percent of

ate, on average, in at least 70 percent of soffered. (Core)

must have an evaluative component to nd educational effectiveness. (Core)

months of dedicated critical care re of infants and children. (Core)

r months of dedicated critical care re of infants and children. (Core) periences must be at the PGY-2 level or

e FTE months, or 20 percent of all ers, dedicated to the care of pediatric ge in the pediatric emergency department

onths should be in an emergency setting.

critical care of infants and children.

east 10 low-risk normal spontaneous

east 60 percent of each resident's clinical es dedicated to the care of pediatric ge in the pediatric emergency department, cy department under the supervision of mbers. (Core)

ant number of critically ill or critically ites. (Core)

admitted to intensive care units, operative atment in the emergency department.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
IV.C.5.	Resident Experiences	4.11.f.	Resident Experiences Each resident must maintain, in ar of all major resuscitations and proc educational program. (Core)
IV.C.5.a)	Each resident must maintain, in an accurate and timely manner, a record of all major resuscitations and procedures performed throughout the entire educational program. (Core)	4.11.f.	Resident Experiences Each resident must maintain, in ar of all major resuscitations and proc educational program. (Core)
IV.C.5.a).(1)	The record must document each procedure type, adult or pediatric patient, and circumstances of each procedure (live or simulation). (Core)	, 4.11.f.1.	The record must document each p and circumstances of each proced
IV.C.5.a).(2)	Only one resident must be credited with the direction of each resuscitation and the performance of each procedure. (Core)	4.11.f.2.	Only one resident must be credited and the performance of each proce
IV.C.5.a).(3)	Resident experiences with major resuscitations and procedures must at least meet the procedural minimums as defined by the Review Committee where indicated. (Core)	4.11.f.3.	Resident experiences with major re least meet the procedural minimum where indicated. (Core)
IV.C.5.b)	Residents must have experience in emergency medical services (EMS), emergency preparedness, and disaster management. (Core)	4.11.g.	Residents must have experience in emergency preparedness, and dis
IV.C.5.b).(1)	EMS experiences must include ground unit runs and should include direct medical oversight. (Core)	÷	EMS experiences must include gro medical oversight. (Core)
IV.C.5.b).(2)	This should include participation in multi-casualty incident drills. (Core)	4.11.g.2.	This should include participation in
IV.C.5.b).(3)	If programs allow residents to ride in air ambulance units, the residents must be notified in writing of the associated risks prior to their first flight. (Core)	4.11.g.3.	If programs allow residents to ride must be notified in writing of the as (Core)
IV.C.5.b).(3).(a)	Residents must be given the opportunity to opt out of riding in air ambulance units at any point in residency. (Core)	4.11.g.3.a.	Residents must be given the oppo ambulance units at any point in res
	Scholarship		
	Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.		Scholarship Medicine is both an art and a sc scientist who cares for patients. critically, evaluate the literature, knowledge, and practice lifelong must create an environment tha through resident participation in activities may include discovery teaching.
	The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the		The ACGME recognizes the divertiant programs prepare physician clinicians, scientists, and educa scholarship will reflect its missis community it serves. For examp their scholarly activity on quality and/or teaching, while other pro-
IV.D.	focus for scholarship.	[None]	classic forms of biomedical rese

an accurate and timely manner, a record rocedures performed throughout the entire

an accurate and timely manner, a record rocedures performed throughout the entire

procedure type, adult or pediatric patient, edure (live or simulation). (Core)

ed with the direction of each resuscitation ocedure. (Core)

r resuscitations and procedures must at ums as defined by the Review Committee

in emergency medical services (EMS), isaster management. (Core)

ground unit runs and should include direct

in multi-casualty incident drills. (Core)

de in air ambulance units, the residents associated risks prior to their first flight.

portunity to opt out of riding in air residency. (Core)

science. The physician is a humanistic ts. This requires the ability to think re, appropriately assimilate new ong learning. The program and faculty hat fosters the acquisition of such skills in scholarly activities. Scholarly ery, integration, application, and

iversity of residencies and anticipates ians for a variety of roles, including cators. It is expected that the program's sion(s) and aims, and the needs of the nple, some programs may concentrate lity improvement, population health, rograms might choose to utilize more esearch as the focus for scholarship.

Requirement Number -		Reformatted	
Roman Numerals	Requirement Language	Requirement Number	Requirement Language
			Program Responsibilities
			The program must demonstrate evidence of sch
IV.D.1.	Program Responsibilities	4.13.	consistent with its mission(s) and aims. (Core)
			Program Responsibilities
	The program must demonstrate evidence of scholarly activities		The program must demonstrate evidence of sch
IV.D.1.a)	consistent with its mission(s) and aims. (Core)	4.13.	consistent with its mission(s) and aims. (Core)
	The program, in partnership with its Sponsoring Institution, must		The program, in partnership with its Sponsoring
	allocate adequate resources to facilitate resident and faculty		allocate adequate resources to facilitate residen
IV.D.1.b)	involvement in scholarly activities. (Core)	4.13.a.	involvement in scholarly activities. (Core)
	The program must advance residents' knowledge and practice of the		The program must advance residents' knowledg
IV.D.1.c)	scholarly approach to evidence-based patient care. (Core)	4.13.b.	scholarly approach to evidence-based patient ca
,			
			Faculty Scholarly Activity
			Among their scholarly activity, programs must c
			accomplishments in at least three of the following
			• Research in basic science, education, translati
			care, or population health
			<ul> <li>Peer-reviewed grants</li> </ul>
			• Quality improvement and/or patient safety initi
			• Systematic reviews, meta-analyses, review arti
			medical textbooks, or case reports
			Creation of curricula, evaluation tools, didaction
			activities, or electronic educational materials
			Contribution to professional committees, educ
			or editorial boards
IV.D.2.	Faculty Scholarly Activity	4.14.	Innovations in education
			Faculty Scholarly Activity
	Among their scholarly activity, programs must demonstrate		Among their scholarly activity, programs must o
	accomplishments in at least three of the following domains: (Core)		accomplishments in at least three of the following
	• Research in basic science, education, translational science, patient		• Research in basic science, education, translati
	care, or population health		care, or population health
	Peer-reviewed grants		Peer-reviewed grants
	<ul> <li>Quality improvement and/or patient safety initiatives</li> </ul>		Quality improvement and/or patient safety initiation
	• Systematic reviews, meta-analyses, review articles, chapters in		Systematic reviews, meta-analyses, review arti
	medical textbooks, or case reports		medical textbooks, or case reports
	Creation of curricula, evaluation tools, didactic educational		Creation of curricula, evaluation tools, didaction
	activities, or electronic educational materials		activities, or electronic educational materials
	Contribution to professional committees, educational		Contribution to professional committees, educ
	organizations, or editorial boards		or editorial boards
IV.D.2.a)	Innovations in education	4.14.	Innovations in education

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ng Institution, must ent and faculty

edge and practice of the care. (Core)

demonstrate wing domains: (Core)

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demonstrate wing domains: (Core)

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- articles, chapters in
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- ucational organizations,

Requirement Number -		Reformatted	
Roman Numerals	Requirement Language	Requirement Number	Requirem
			The program must demonstrate within and external to the progra
			<ul> <li>faculty participation in grand r improvement presentations, poor non-peer-reviewed print/electror book chapters, textbooks, webin committees, or serving as a jour member, or editor; (Outcome)</li> </ul>
	The program must demonstrate dissemination of scholarly activity		- near reviewed publication (Qu
IV.D.2.b)	within and external to the program by the following methods:	4.14.a.	peer-reviewed publication. (Ou The program must demonstrate within and external to the program
	faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal		<ul> <li>faculty participation in grand re- improvement presentations, pod non-peer-reviewed print/electron book chapters, textbooks, webin committees, or serving as a jour member, or editor; (Outcome)</li> </ul>
IV.D.2.b).(1)	editorial board member, or editor; (Outcome)	4.14.a.	• peer-reviewed publication. (Ou
			The program must demonstrate within and external to the progra
			• faculty participation in grand re- improvement presentations, pod non-peer-reviewed print/electron book chapters, textbooks, webin committees, or serving as a jour member, or editor; (Outcome)
IV.D.2.b).(2)	peer-reviewed publication. (Outcome)	4.14.a.	peer-reviewed publication. (Out
IV.D.3.	Resident Scholarly Activity	4.15.	Resident Scholarly Activity Residents must participate in sc
IV.D.3.a)	Residents must participate in scholarship. (Core)	4.15.	Resident Scholarly Activity Residents must participate in sc
IV.D.3.b)	The curriculum must advance the residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)	4.15.a.	The curriculum must advance the r principles of research, including ho explained to patients, and applied t

e dissemination of scholarly activity ram by the following methods:

l rounds, posters, workshops, quality odium presentations, grant leadership, onic resources, articles or publications, pinars, service on professional urnal reviewer, journal editorial board

#### Outcome)

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#### Outcome)

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e residents' knowledge of the basic now research is conducted, evaluated, d to patient care. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
			At the time of graduation, each res
			• active participation in a research implementation of an original resea funded basic science or clinical out participation in an emergency depa (Outcome)
			<ul> <li>presentation of grand rounds, pos presentations, podium presentation</li> </ul>
			• grant leadership, non-peer-review publications, book chapters, textbo committees, or serving as a journal member, or editor; or, (Outcome)
IV.D.3.c)	At the time of graduation, each resident should demonstrate:	4.15.b.	• peer-reviewed publications. (Outo
			At the time of graduation, each res • active participation in a research implementation of an original resea funded basic science or clinical out participation in an emergency depa (Outcome)
			<ul> <li>presentation of grand rounds, pos presentations, podium presentation</li> </ul>
	active participation in a research project, or formulation and implementation of an original research project, including funded and non- funded basic science or clinical outcomes research, as well as active participation in an emergency department quality improvement project; or,		• grant leadership, non-peer-review publications, book chapters, textbo committees, or serving as a journa member, or editor; or, (Outcome)
IV.D.3.c).(1)	(Outcome)	4.15.b.	• peer-reviewed publications. (Outo

esident should demonstrate:

h project, or formulation and earch project, including funded and nonoutcomes research, as well as active partment quality improvement project; or,

osters, workshops, quality improvement ions, webinars; or, (Core)

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esident should demonstrate:

h project, or formulation and earch project, including funded and nonoutcomes research, as well as active partment quality improvement project; or,

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Roman Numerals	Requirement Language	Requirement Number	Requirem
			At the time of graduation, each res
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			• active participation in a research
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			funded basic science or clinical ou
			participation in an emergency depa (Outcome)
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			a grant landarahin, nan haar ravia
			<ul> <li>grant leadership, non-peer-review publications, book chapters, textbo</li> </ul>
			committees, or serving as a journa
			member, or editor; or, (Outcome)
	presentation of grand rounds, posters, workshops, quality improvement		
IV.D.3.c).(2)	presentations, podium presentations, webinars; or, (Core)	4.15.b.	• peer-reviewed publications. (Out
			At the time of graduation, each res
			active participation in a research
			implementation of an original resea
			funded basic science or clinical ou
			participation in an emergency depa
			(Outcome)
			• presentation of grand rounds, pos
			presentations, podium presentation
			• grant leadership, non-peer-reviev
			publications, book chapters, textbo
	grant leadership, non-peer-reviewed print/electronic resources, articles or		committees, or serving as a journa
	publications, book chapters, textbooks, service on professional		member, or editor; or, (Outcome)
	committees, or serving as a journal reviewer, journal editorial board		
IV.D.3.c).(3)	member, or editor; or, (Outcome)	4.15.b.	• peer-reviewed publications. (Outo
V.	Evaluation	Section 5	Section 5: Evaluation
			Resident Evaluation: Feedback
			Faculty members must directly of
V.A.	Resident Evaluation	5.1.	provide feedback on resident pe similar educational assignment.
v.A.		5.1.	Resident Evaluation: Feedback
			Faculty members must directly of
			provide feedback on resident pe
V.A.1.	Feedback and Evaluation	5.1.	similar educational assignment.
			Resident Evaluation: Feedback
	Faculty members must directly observe, evaluate, and frequently		Faculty members must directly of
	provide feedback on resident performance during each rotation or		provide feedback on resident pe
V.A.1.a)	similar educational assignment. (Core)	5.1.	similar educational assignment.

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esident should demonstrate:
h project, or formulation and
earch project, including funded and non-
outcomes research, as well as active
partment quality improvement project; or,
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Requirement Language	Reformatted Requirement Number	Requirem
Evaluation must be documented at the completion of the assignment. (Core)	5.1.a.	Evaluation must be documented (Core)
For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)	5.1.a.1.	For block rotations of greater th evaluation must be documented
Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)	5.1.a.2.	Longitudinal experiences, such other clinical responsibilities, m months and at completion. (Core
The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)	5.1.b.	The program must provide an ol based on the Competencies and (Core)
use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)	5.1.b.1.	The program must use multiple peers, patients, self, and other p
provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)	5.1.b.2.	The program must provide that i Competency Committee for its s performance and improvement t
The program director or their designee, with input from the Clinical Competency Committee, must:	[None]	
meet with and review with each resident their documented semi- annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)	5.1.c.	The program director or their de Competency Committee, must n resident their documented semi- including progress along the sp
The program director must verify each resident's records of major resuscitations and procedures as part of the semiannual evaluation. (Core)	5.1.c.1.	The program director must verify e resuscitations and procedures as p
assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)	5.1.d.	The program director or their de Competency Committee, must a individualized learning plans to identify areas for growth. (Core)
	5.1.e.	The program director or their de Competency Committee, must d progress, following institutional
A plan to remedy deficiencies must be in writing and on file. (Core)	5.1.e.1.	A plan to remedy deficiencies mus
Progress and improvement must be monitored at a minimum of every three months if a resident has been identified as needing a remediation plan. (Core)	5.1.e.1.a.	Progress and improvement must b months if a resident has been iden (Core)
At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable, (Core)	5.1.f.	At least annually, there must be resident that includes their read the program, if applicable. (Core
At least annually, each resident's competency in procedures and		At least annually, each resident's or resuscitations must be formally evaluated to the formally evaluated to the formal of the f
The evaluations of a resident's performance must be accessible for review by the resident. (Core)	5.1.g.	The evaluations of a resident's preview by the resident. (Core)
		Resident Evaluation: Final Evalu The program director must prov resident upon completion of the
	Evaluation must be documented at the completion of the assignment. (Core) For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core) Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core) The program director or their designee, with input from the Clinical Competency Committee, must: meet with and review with each resident their documented semi- annual evaluation of performance, including progress along the specialty-specific Milestones; (Core) The program director must verify each resident's records of major resuscitations and procedures as part of the semiannual evaluation. (Core) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core) A plan to remedy deficiencies must be in writing and on file. (Core) Progress and improvement must be monitored at a minimum of every three months if a resident has been identified as needing a remediation plan. (Core) At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core) At least annually, each resident's competency in procedures and resuscitations must be formality evaluated by the program director. (Core) The evaluations of a resident's performance must be accessible for review by the resident. (Core)	Requirement LanguageRequirement NumberEvaluation must be documented at the completion of the assignment. (Core)5.1.a.For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)5.1.a.1.Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)5.1.a.2.The program must provide an objective performance evaluation based on the Competencies and the speciality-specific Milestones, and must: (Core)5.1.b.use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)5.1.b.1.provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice, (Core)5.1.b.2.The program director or their designee, with input from the Clinical Competency Committee, must:[None]meet with and review with each resident their documented semi- annual evaluation of performance, including progress along the speciality-specific Milestones; (Core)5.1.c.The program director must verify each resident's records of major resuscitations and procedures as part of the semiannual evaluation. (Core)5.1.e.develop plans for residents failing to progress, following linstitutional policies and procedures. (Core)5.1.e.A plan to remedy deficiencies must be in writing and on file. (Core)5.1.e.1.a.At least annually, there must be a summative evaluation of each resident tha includes their readines to progress to the next year of the progra

#### ement Language ed at the completion of the assignment.

than three months in duration, ed at least every three months. (Core)

h as continuity clinic in the context of must be evaluated at least every three pre)

objective performance evaluation nd the specialty-specific Milestones.

le evaluators (e.g., faculty members, r professional staff members). (Core)

t information to the Clinical s synthesis of progressive resident t toward unsupervised practice. (Core)

designee, with input from the Clinical t meet with and review with each mi-annual evaluation of performance, specialty-specific Milestones. (Core)

each resident's records of major part of the semiannual evaluation. (Core)

designee, with input from the Clinical t assist residents in developing to capitalize on their strengths and re)

designee, with input from the Clinical develop plans for residents failing to al policies and procedures. (Core) ust be in writing and on file. (Core)

t be monitored at a minimum of every three entified as needing a remediation plan.

be a summative evaluation of each adiness to progress to the next year of bre)

s competency in procedures and evaluated by the program director. (Core)

performance must be accessible for

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ovide a final evaluation for each ne program. (Core)

Requirement Number -		Reformatted	
Roman Numerals	Requirement Language	Requirement Number	Requirement Language
			Resident Evaluation: Final Evaluation
V.A.2.a)	The program director must provide a final evaluation for each resident upon completion of the program. (Core)	5.2.	The program director must provide a final evaluation for each resident upon completion of the program. (Core)
V.A.2.a).(1)	The specialty-specific Milestones, and when applicable the specialty- specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)		The specialty-specific Milestones, and when applicable the specialty- specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)
V.A.2.a).(2)	The final evaluation must:	[None]	
V.A.2.a).(2).(a)	become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)	5.2.b.	The final evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. (Core)
V.A.2.a).(2).(b)	verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core)
V.A.2.a).(2).(c)	be shared with the resident upon completion of the program. (Core)	5.2.d.	The final evaluation must be shared with the resident upon completion of the program. (Core)
V.A.3.	A Clinical Competency Committee must be appointed by the program director. (Core)	5.3.	Clinical Competency Committee A Clinical Competency Committee must be appointed by the program director. (Core)
V.A.3.a)	At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)	5.3.a.	At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)
V.A.3.a).(1)	Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)	5.3.b.	Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)
V.A.3.b)	The Clinical Competency Committee must:	[None]	
V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)	5.3.c.	The Clinical Competency Committee must review all resident evaluations at least semi-annually. (Core)
V.A.3.b).(2)	determine each resident's progress on achievement of the specialty- specific Milestones; and, (Core)	5.3.d.	The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones. (Core)
V.A.3.b).(3)	meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)	5.3.e.	The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)
V.B.	Faculty Evaluation	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)
V.B.1.	The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

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V.B.1.a)	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)	5.4.a.	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)
V.B.1.b)	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)	5.4.b.	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)
V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feedback on their evaluations at least annually. (Core)
V.B.3.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)	5.4.d.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)
V.C.	Program Evaluation and Improvement	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1.	The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1.a)	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)	5.5.a.	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
V.C.1.b).(1)	review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. <sup>(Core)</sup>
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)
V.C.1.b).(3)	review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)
V.C.1.c)	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)	5.5.e.	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)
V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)	5.5.f.	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)
V.C.1.e)	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)	5.5.g.	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)
V.C.2.	The program must complete a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must complete a Self-Study and submit it to the DIO. (Core)

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	One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.		Board Certification One goal of ACGME-accredited e who seek and achieve board cert effectiveness of the educational
V.C.3.	The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.	[None]	The program director should end graduates to take the certifying e American Board of Medical Spec American Osteopathic Association
V.C.3.a)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.	Board Certification For specialties in which the ABM certifying board offer(s) an annua three years, the program's aggre examination for the first time mu percentile of programs in that sp
V.C.3.b)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.a.	For specialties in which the ABM certifying board offer(s) a biennia years, the program's aggregate p examination for the first time mu percentile of programs in that sp
V.C.3.c)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.b.	For specialties in which the ABM certifying board offer(s) an annu- years, the program's aggregate p examination for the first time mu percentile of programs in that sp
V.C.3.d)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.c.	For specialties in which the ABM certifying board offer(s) a biennia years, the program's aggregate p examination for the first time mu percentile of programs in that sp
V.C.3.e)	For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)	5.6.d.	For each of the exams referenced graduates over the time period s achieved an 80 percent pass rate matter the percentile rank of the specialty. <sup>(Outcome)</sup>
V.C.3.f)	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)	5.6.e.	Programs must report, in ADS, b the cohort of board-eligible resid earlier. <sup>(Core)</sup>

d education is to educate physicians ertification. One measure of the al program is the ultimate pass rate.

ncourage all eligible program g examination offered by the applicable ecialties (ABMS) member board or ation (AOA) certifying board.

BMS member board and/or AOA nual written exam, in the preceding regate pass rate of those taking the nust be higher than the bottom fifth specialty. (Outcome)

BMS member board and/or AOA nial written exam, in the preceding six e pass rate of those taking the nust be higher than the bottom fifth specialty. <sup>(Outcome)</sup>

BMS member board and/or AOA nual oral exam, in the preceding three e pass rate of those taking the nust be higher than the bottom fifth specialty. <sup>(Outcome)</sup>

BMS member board and/or AOA nial oral exam, in the preceding six e pass rate of those taking the nust be higher than the bottom fifth specialty. <sup>(Outcome)</sup>

ced in 5.6.a.-c., any program whose I specified in the requirement have ate will have met this requirement, no he program for pass rate in that

board certification status annually for sidents that graduated seven years

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
			Section 6: The Learning and Wo
	The Learning and Working Environment		The Learning and Working Envi
	Residency education must occur in the context of a learning and working environment that emphasizes the following principles:		Residency education must occu working environment that emph
	• Excellence in the safety and quality of care rendered to patients by residents today		• Excellence in the safety and quiresidents today
	• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice		• Excellence in the safety and quitoday's residents in their future
	• Excellence in professionalism		• Excellence in professionalism
	<ul> <li>Appreciation for the privilege of caring for patients</li> </ul>		• Appreciation for the privilege of
VI	<ul> <li>Commitment to the well-being of the students, residents, faculty members, and all members of the health care team</li> </ul>	Section 6	• Commitment to the well-being members, and all members of the second se
VI.A.	Patient Safety, Quality Improvement, Supervision, and Accountability	[None]	
VI.A.1.	Patient Safety and Quality Improvement	[None]	
VI.A.1.a)	Patient Safety	[None]	
VI.A.1.a).(1)	Culture of Safety A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.	[None]	Culture of Safety A culture of safety requires con vulnerabilities and a willingness effective organization has forma knowledge, skills, and attitudes order to identify areas for impro
VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)	6.1.	The program, its faculty, resider participate in patient safety syst safety. (Core)
VI.A.1.a).(2)	Patient Safety Events Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.	[None]	Patient Safety Events Reporting, investigation, and fo and unsafe conditions are pivot safety, and are essential for the program. Feedback and experie developing true competence in institute sustainable systems-ba safety vulnerabilities.
	Residents, fellows, faculty members, and other clinical staff		
VI.A.1.a).(2).(a) VI.A.1.a).(2).(a).(i)	members must: know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)	[None] 6.2.	Residents, fellows, faculty mem must know their responsibilities and unsafe conditions at the cli such events. (Core)

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cur in the context of a learning and phasizes the following principles:

quality of care rendered to patients by

quality of care rendered to patients by re practice

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ng of the students, residents, faculty the health care team

ontinuous identification of ess to transparently deal with them. An mal mechanisms to assess the es of its personnel toward safety in provement.

lents, and fellows must actively /stems and contribute to a culture of

follow-up of safety events, near misses, rotal mechanisms for improving patient he success of any patient safety riential learning are essential to in the ability to identify causes and -based changes to ameliorate patient

embers, and other clinical staff members les in reporting patient safety events clinical site, including how to report

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
VI.A.1.a).(2).(a).(ii)	be provided with summary information of their institution's patient safety reports. (Core)	6.2.a.	Residents, fellows, faculty mem must be provided with summary patient safety reports. <sup>(Core)</sup>
VI.A.1.a).(2).(b)	Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)	6.3.	Residents must participate as te interprofessional clinical patient activities, such as root cause an analysis, as well as formulation
	Quality Metrics Access to data is essential to prioritizing activities for care		Quality Metrics Access to data is essential to pr
VI.A.1.a).(3) VI.A.1.a).(3).(a)	<ul> <li><i>improvement and evaluating success of improvement efforts.</i></li> <li>Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)</li> </ul>	[None] 6.4.	improvement and evaluating suc Residents and faculty members and benchmarks related to their
VI.A.2.	Supervision and Accountability	[None]	Supervision and Accountability Although the attending physicia care of the patient, every physic accountability for their efforts in programs, in partnership with the widely communicate, and monite and accountability as it relates to Supervision in the setting of gras safe and effective care to patient development of the skills, knowle the unsupervised practice of me for continued professional grow
	Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.		Supervision and Accountability Although the attending physicia care of the patient, every physic accountability for their efforts in programs, in partnership with th widely communicate, and monite and accountability as it relates to Supervision in the setting of gra
VI.A.2.a)	safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.		safe and effective care to patien development of the skills, know the unsupervised practice of me for continued professional grow
VI.A.2.a).(1)	Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)	6.5.	Residents and faculty members respective roles in that patient's care. This information must be a members, other members of the (Core)

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mbers, and other clinical staff members ry information of their institution's

team members in real and/or simulated nt safety and quality improvement analyses or other activities that include n and implementation of actions. (Core)

prioritizing activities for care uccess of improvement efforts. 's must receive data on quality metrics ir patient populations. (Core)

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raduate medical education provides ents; ensures each resident's wledge, and attitudes required to enter nedicine; and establishes a foundation wth.

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ian is ultimately responsible for the ician shares in the responsibility and in the provision of care. Effective their Sponsoring Institutions, define, itor a structured chain of responsibility to the supervision of all patient care.

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s must inform each patient of their 's care when providing direct patient available to residents, faculty he health care team, and patients.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
VI.A.2.a).(1).(a)	This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)	6.5.	Residents and faculty members respective roles in that patient's care. This information must be a members, other members of the (Core)
VI.A.2.a).(2)	The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)	6.6.	The program must demonstrate supervision in place for all resid of training and ability, as well as Supervision may be exercised th appropriate to the situation. (Co
VI.A.2.b)	Levels of Supervision To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:	[None]	Levels of Supervision To promote appropriate residen graded authority and responsibi following classification of super
VI.A.2.b).(1)	Direct Supervision	6.7.	Direct Supervision The supervising physician is ph during the key portions of the pa The supervising physician and/o with the resident and the superv monitoring the patient care thro technology.
VI.A.2.b).(1).(a)	the supervising physician is physically present with the resident during the key portions of the patient interaction; or,	6.7.	Direct Supervision The supervising physician is ph during the key portions of the pa The supervising physician and/o with the resident and the superv monitoring the patient care thro technology.
VI.A.2.b).(1).(a).(i)	PGY-1 residents must initially be supervised directly, only as described in VI.A.2.b).(1).(a). (Core)	6.7.a.	PGY-1 residents must initially be described in the above definition Direct Supervision
VI.A.2.b).(1).(b)	the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.	6.7.	The supervising physician is ph during the key portions of the pa The supervising physician and/o with the resident and the superv monitoring the patient care thro technology.
VI.A.2.b).(2)	Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.	[None]	The supervising physician is no visual or audio supervision but resident for guidance and is ava supervision.

rs must inform each patient of their t's care when providing direct patient e available to residents, faculty he health care team, and patients.

te that the appropriate level of sidents is based on each resident's level as patient complexity and acuity. I through a variety of methods, as Core)

ent supervision while providing for ibility, the program must use the pervision.

physically present with the resident patient interaction.

d/or patient is not physically present ervising physician is concurrently rough appropriate telecommunication

ohysically present with the resident patient interaction.

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be supervised directly, only as ion. (Core)

physically present with the resident patient interaction.

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not providing physical or concurrent It is immediately available to the vailable to provide appropriate direct

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
VI.A.2.b).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.	[None]	Oversight The supervising physician is av procedures/encounters with fee delivered.
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physician is required. (Core)
VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)	6.9.	The privilege of progressive aut independence, and a supervisor each resident must be assigned members. (Core)
VI.A.2.d).(1)	The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)	6.9.a.	The program director must evalues specific criteria, guided by the M
VI.A.2.d).(2)	Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)	6.9.b.	Faculty members functioning as delegate portions of care to resi patient and the skills of each res
VI.A.2.d).(3)	Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)	6.9.c.	Senior residents or fellows shou junior residents in recognition o independence, based on the nee the individual resident or fellow.
VI.A.2.e)	Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)	6.10.	Programs must set guidelines for residents must communicate wi (Core)
VI.A.2.e).(1)	Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)	6.10.a.	Each resident must know the lin the circumstances under which conditional independence. (Outo
VI.A.2.f)	Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)	6.11.	Faculty supervision assignment assess the knowledge and skills the resident the appropriate leve responsibility. (Core)
VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with th educate residents and faculty m and ethical responsibilities of pl their obligation to be appropriate required by their patients. (Core
VI.B.1.	Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)	6.12.	Professionalism Programs, in partnership with th educate residents and faculty m and ethical responsibilities of pl their obligation to be appropriate required by their patients. (Core
VI.B.2.	The learning objectives of the program must:	[None]	
VI.B.2.a)	be accomplished without excessive reliance on residents to fulfill non-physician obligations; (Core)	6.12.a.	The learning objectives of the pr without excessive reliance on re obligations. <sup>(Core)</sup>
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the properties of the

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available to provide review of eedback provided after care is

n physical presence of a supervising

uthority and responsibility, conditional ory role in patient care delegated to ed by the program director and faculty

aluate each resident's abilities based on Milestones. (Core)

as supervising physicians must esidents based on the needs of the resident. (Core)

ould serve in a supervisory role to of their progress toward needs of each patient and the skills of w. (Detail)

for circumstances and events in which with the supervising faculty member(s).

limits of their scope of authority, and h the resident is permitted to act with utcome)

ents must be of sufficient duration to ills of each resident and to delegate to evel of patient care authority and

their Sponsoring Institutions, must members concerning the professional physicians, including but not limited to ately rested and fit to provide the care re)

their Sponsoring Institutions, must members concerning the professional physicians, including but not limited to ately rested and fit to provide the care re)

program must be accomplished residents to fulfill non-physician

program must ensure manageable Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
VI.B.2.c)	include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)	6.12.c.	The learning objectives of the p enhance the meaning that each being a physician, including pro administrative support, promoti flexibility, and enhancing profes
VI.B.3.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)	6.12.d.	The program director, in partner must provide a culture of profes and personal responsibility. (Co
VI.B.4.	Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)	6.12.e.	Residents and faculty members of their personal role in the safe their care, including the ability to events. (Core)
VI.B.5.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)	6.12.f.	Programs, in partnership with the provide a professional, equitable that is psychologically safe and sexual and other forms of haras coercion of students, residents,
VI.B.6.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)	6.12.g.	Programs, in partnership with the have a process for education of unprofessional behavior and a c investigating, and addressing su
	Well-Being Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.		Well-Being Psychological, emotional, and p development of the competent, require proactive attention to life being requires that physicians r managing their own real-life stre support other members of the h components of professionalism modeled, learned, and nurtured residency training.
	Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the		Residents and faculty members depression. Programs, in partne Institutions, have the same resp other aspects of resident compe of the health care team share re other. A positive culture in a clin constructive behaviors, and pre
VI.C. VI.C.1.	skills and attitudes needed to thrive throughout their careers. The responsibility of the program, in partnership with the Sponsoring Institution, must include:	[None] 6.13.	attitudes needed to thrive throug The responsibility of the program Institution, must include:
VI.C.1.a)	attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)	6.13.a.	attention to scheduling, work in impacts resident well-being; (Co
VI.C.1.b)	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)	6.13.b.	evaluating workplace safety dat residents and faculty members;

#### ement Language

program must include efforts to th resident finds in the experience of protecting time with patients, providing oting progressive independence and ressional relationships. (Core)

ership with the Sponsoring Institution, essionalism that supports patient safety Core)

rs must demonstrate an understanding fety and welfare of patients entrusted to / to report unsafe conditions and safety

their Sponsoring Institutions, must ble, respectful, and civil environment ad that is free from discrimination, assment, mistreatment, abuse, or ts, faculty, and staff. (Core)

their Sponsoring Institutions, should of residents and faculty regarding a confidential process for reporting, such concerns. (Core)

I physical well-being are critical in the t, caring, and resilient physician and life inside and outside of medicine. Wells retain the joy in medicine while tresses. Self-care and responsibility to health care team are important cm; they are also skills that must be ed in the context of other aspects of

rs are at risk for burnout and mership with their Sponsoring sponsibility to address well-being as petence. Physicians and all members responsibility for the well-being of each clinical learning environment models repares residents with the skills and bughout their careers.

ram, in partnership with the Sponsoring

intensity, and work compression that Core)

ata and addressing the safety of s; (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.C.1.c)	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)	6.13.c.	policies and programs that encourage optimal r member well-being; and, (Core)
VI.C.1.c).(1)	Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)	6.13.c.1.	Residents must be given the opportunity to atte health, and dental care appointments, including during their working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty members in:
VI.C.1.d).(1)	identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)	6.13.d.1.	identification of the symptoms of burnout, deprouse disorders, suicidal ideation, or potential for means to assist those who experience these co
VI.C.1.d).(2)	recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)	6.13.d.2.	recognition of these symptoms in themselves a appropriate care; and, (Core)
VI.C.1.d).(3)	access to appropriate tools for self-screening. (Core)	6.13.d.3.	access to appropriate tools for self-screening. (
VI.C.1.e)	providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)	6.13.e.	providing access to confidential, affordable mer assessment, counseling, and treatment, includin and emergent care 24 hours a day, seven days a
VI.C.2.	There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)	6.14.	There are circumstances in which residents may work, including but not limited to fatigue, illness and medical, parental, or caregiver leave. Each an appropriate length of absence for residents u patient care responsibilities. (Core)
	The program must have policies and procedures in place to ensure		The program must have policies and procedure
VI.C.2.a)	coverage of patient care and ensure continuity of patient care. (Core)	6.14.a.	coverage of patient care and ensure continuity of
VI.C.2.b)	These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)	6.14.b.	These policies must be implemented without fea consequences for the resident who is or was un clinical work. (Core)
VI.D.	Fatigue Mitigation	6.15.	Fatigue Mitigation Programs must educate all residents and faculty recognition of the signs of fatigue and sleep de management, and fatigue mitigation processes.
VI.D.1.	Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)	6.15.	Fatigue Mitigation Programs must educate all residents and faculty recognition of the signs of fatigue and sleep dep management, and fatigue mitigation processes.
VI.D.2.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)	6.16.	The program, in partnership with its Sponsoring ensure adequate sleep facilities and safe transp residents who may be too fatigued to safely retu
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
VI.E.1.	Clinical Responsibilities The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)	6.17.	Clinical Responsibilities The clinical responsibilities for each resident m level, patient safety, resident ability, severity an patient illness/condition, and available support
VI.E.1.a)	When emergency medicine residents are on emergency medicine rotations, the following standards apply: (Core)	6.17.a.	When emergency medicine residents are on emerg rotations, the following standards apply: (Core)
VI.E.1.a).(1)	While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. (Core)	6.17.a.1.	While on duty in the emergency department, reside than 12 continuous scheduled hours. (Core)

l resident and faculty

tend medical, mental ng those scheduled

pression, and substance or violence, including conditions; (Core) and how to seek

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ental health ding access to urgent a week. (Core)

nay be unable to attend ess, family emergencies, h program must allow unable to perform their

res in place to ensure y of patient care. (Core)

fear of negative unable to provide the

Ity members in deprivation, alertness s. (Detail)

Ity members in leprivation, alertness s. (Detail)

ng Institution, must sportation options for eturn home. (Core)

must be based on PGY and complexity of rt services. (Core)

rgency medicine

dents may not work longer

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
VI.E.1.a).(1).(a)	There must be at least one equivalent period of continuous time off between scheduled work period. (Core)	6.17.a.2.	There must be at least one equiva between scheduled work period. (
VI.E.1.a).(2)	A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week. (Core)	6.17.a.3.	A resident must not work more that patients in the emergency departmeters. (Core)
VI.E.1.a).(3)	Emergency medicine residents must have a minimum of one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period. (Core)	6.17.a.4.	Emergency medicine residents mu period) free per each seven-day per four-week period. (Core)
VI.E.2.	Teamwork Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)	6.18.	Teamwork Residents must care for patients communication and promotes s care in the specialty and larger l
VI.E.2.a)	Interprofessional teams should be used to ensure effective and efficient communication for appropriate patient care for emergency medicine department admissions, transfers, and discharges. (Detail)	6.18.a.	Interprofessional teams should be communication for appropriate pat department admissions, transfers,
VI.E.3.	Transitions of Care	6.19.	Transitions of Care Programs must design clinical a patient care, including their safe
VI.E.3.a)	Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)	6.19.	Transitions of Care Programs must design clinical a patient care, including their safe
VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)	6.19.a.	Programs, in partnership with the ensure and monitor effective, st facilitate both continuity of care
VI.E.3.c)	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)	6.19.b.	Programs must ensure that resi communicating with team memb (Outcome)
VI.F.	Clinical Experience and Education Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.	[None]	Clinical Experience and Educati Programs, in partnership with th design an effective program stru residents with educational and o well as reasonable opportunities
VI.F.1.	Maximum Hours of Clinical and Educational Work per Week Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)		Maximum Hours of Clinical and Clinical and educational work he 80 hours per week, averaged ov in-house clinical and educationa home, and all moonlighting. (Co
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	Mandatory Time Free of Clinical Residents should have eight ho work and education periods. (De
VI.F.2.a)	Residents should have eight hours off between scheduled clinical work and education periods. (Detail)	6.21.	Mandatory Time Free of Clinical Residents should have eight ho work and education periods. (De

#### ement Language

valent period of continuous time off . (Core)

han 60 scheduled hours per week seeing tment, and no more than 72 total hours per

must have a minimum of one day (24-hour period. This cannot be averaged over a

#### nts in an environment that maximizes safe, interprofessional, team-based r health system. (Core)

be used to ensure effective and efficient batient care for emergency medicine rs, and discharges. (Detail)

I assignments to optimize transitions in afety, frequency, and structure. (Core)

l assignments to optimize transitions in afety, frequency, and structure. (Core)

their Sponsoring Institutions, must structured hand-off processes to re and patient safety. (Core) sidents are competent in

mbers in the hand-off process.

#### ation

their Sponsoring Institutions, must tructure that is configured to provide d clinical experience opportunities, as ies for rest and personal activities.

d Educational Work per Week hours must be limited to no more than over a four-week period, inclusive of all onal activities, clinical work done from Core)

al Work and Education nours off between scheduled clinical Detail)

al Work and Education nours off between scheduled clinical Detail)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
Roman Numerais	Residents must have at least 14 hours free of clinical work and		Residents must have at least 14
VI.F.2.b)	education after 24 hours of in-house call. (Core)	6.21.a.	education after 24 hours of in-ho
VI.F.2.c)	Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)	6.21.b.	Residents must be scheduled fo of clinical work and required edu weeks). At-home call cannot be a
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	Maximum Clinical Work and Edu Clinical and educational work pe 24 hours of continuous schedule
VI.F.3.a)	Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)	6.22.	Maximum Clinical Work and Edu Clinical and educational work pe 24 hours of continuous schedule
VI.F.3.a).(1)	Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)	6.22.a.	Up to four hours of additional tin to patient safety, such as provid and/or resident education. Addit must not be assigned to a reside
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	Clinical and Educational Work H In rare circumstances, after hand resident, on their own initiative, clinical site in the following circu care to a single severely ill or un attention to the needs of a patier unique educational events. (Deta
VI.F.4.a)	In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)	6.23.	Clinical and Educational Work H In rare circumstances, after hand resident, on their own initiative, clinical site in the following circu care to a single severely ill or un attention to the needs of a patier unique educational events. (Deta
VI.F.4.b)	These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)	6.23.a.	These additional hours of care o the 80-hour weekly limit. (Detail)
· ·	A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.		A Review Committee may grant a 10 percent or a maximum of 88 c individual programs based on a
VI.F.4.c)	The Review Committee for Emergency Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.	6.24.	The Review Committee for Emerge for exceptions to the 80-hour limit t
VI.F.5.	Moonlighting	6.25.	Moonlighting Moonlighting must not interfere achieve the goals and objectives must not interfere with the reside compromise patient safety. (Core

### ment Language 4 hours free of clinical work and house call. (Core)

for a minimum of one day in seven free ducation (when averaged over four e assigned on these free days. (Core)

ducation Period Length periods for residents must not exceed

lled clinical assignments. (Core)

ducation Period Length periods for residents must not exceed uled clinical assignments. (Core)

time may be used for activities related iding effective transitions of care, ditional patient care responsibilities dent during this time. (Core)

### Hour Exceptions

nding off all other responsibilities, a e, may elect to remain or return to the cumstances: to continue to provide unstable patient; to give humanistic ent or patient's family; or to attend etail)

### Hour Exceptions

nding off all other responsibilities, a e, may elect to remain or return to the cumstances: to continue to provide unstable patient; to give humanistic ent or patient's family; or to attend etail)

or education must be counted toward il)

et rotation-specific exceptions for up to B clinical and educational work hours to a sound educational rationale.

gency Medicine will not consider requests to the residents' work week.

e with the ability of the resident to es of the educational program, and ident's fitness for work nor ore)

Requirement Number -		Reformatted	
Roman Numerals	Requirement Language	Requirement Number	Requirem
VI.F.5.a)	Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)	6.25.	Moonlighting Moonlighting must not interfere achieve the goals and objective must not interfere with the resid compromise patient safety. (Con
VI.F.5.b)	Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)	6.25.a.	Time spent by residents in inter defined in the ACGME Glossary the 80-hour maximum weekly lir
VI.F.5.c)	PGY-1 residents are not permitted to moonlight. (Core)	6.25.b.	PGY-1 residents are not permitte
VI.F.6.	In-House Night Float Night float must occur within the context of the 80-hour and one-day- off-in-seven requirements. (Core)		In-House Night Float Night float must occur within the off-in-seven requirements. (Core
VI.F.7.	Maximum In-House On-Call Frequency Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)	6.27.	Maximum In-House On-Call Free Residents must be scheduled fo than every third night (when ave (Core)
VI.F.8.	At-Home Call	6.28.	At-Home Call Time spent on patient care activ must count toward the 80-hour r of at-home call is not subject to must satisfy the requirement for and education, when averaged o
VI.F.8.a)	Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)	6.28.	At-Home Call Time spent on patient care activ must count toward the 80-hour r of at-home call is not subject to must satisfy the requirement for and education, when averaged o
·	At-home call must not be so frequent or taxing as to preclude rest or		At-home call must not be so free
VI.F.8.a).(1)	reasonable personal time for each resident. (Core)	6.28.a.	reasonable personal time for eac

re with the ability of the resident to /es of the educational program, and sident's fitness for work nor fore)

ernal and external moonlighting (as ry of Terms) must be counted toward limit. (Core)

tted to moonlight. (Core)

the context of the 80-hour and one-daypre)

requency

for in-house call no more frequently veraged over a four-week period).

tivities by residents on at-home call ir maximum weekly limit. The frequency to the every-third-night limitation, but for one day in seven free of clinical work d over four weeks. (Core)

tivities by residents on at-home call ir maximum weekly limit. The frequency to the every-third-night limitation, but for one day in seven free of clinical work d over four weeks. (Core)

requent or taxing as to preclude rest or each resident. (Core)