Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
Int.A.	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 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 established during graduate medical education persist many years later.	[None]	Definition of Graduate Medical Educa Graduate medical education is the cri development between medical schoo is in this vital phase of the continuum learn to provide optimal patient care is members who not only instruct, but s compassion, cultural sensitivity, prof Graduate medical education transform scholars who care for the patient, pat community; create and integrate new educate future generations of physici patterns established during graduate years later.
	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 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 has as a responsibility for patient care. The ca appropriate faculty supervision and c residents to attain the knowledge, ski empathy required for autonomous pro- develops physicians who focus on ex- equitable, affordable, quality care; an serve. Graduate medical education va group of physicians brings to medical inclusive and psychologically safe lea
Int.A. (Continued)	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 committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.	[None] - (Continued)	foundation for practice-based and life development of the physician, begun through faculty modeling of the effac environment that emphasizes joy in o rigor, and discovery. This transforma and intellectually demanding and occ environments committed to graduate being of patients, residents, fellows, i members of the health care team.

#### nt Language

ation

crucial step of professional ool and autonomous clinical practice. It of medical education that residents of under the supervision of faculty serve as role models of excellence, ofessionalism, and scholarship.

orms medical students into physician atient's family, and a diverse w knowledge into practice; and cians to serve the public. Practice te medical education persist many

a core tenet the graded authority and care of patients is undertaken with conditional independence, allowing kills, attitudes, judgment, and practice. Graduate medical education excellence in delivery of safe, and the health of the populations they values the strength that a diverse cal care, and the importance of learning environments.

in clinical settings that establish the ifelong learning. The professional in in medical school, continues cement of self-interest in a humanistic curiosity, problem-solving, academic nation is often physically, emotionally, ccurs in a variety of clinical learning te medical education and the well-, faculty members, students, and all

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	· Requiremen
	<b>Definition of Specialty</b> Pediatricians are physicians who provide comprehensive patient-centered preventive, acute, and chronic care for the growing and developing child from birth through the transition to adult care. They care for the whole patient, having knowledge to recognize and manage common childhood and adolescent medical, psychosocial, and behavioral issues.		<b>Definition of Specialty</b> Pediatricians are physicians who provide preventive, acute, and chronic care for the birth through the transition to adult care. knowledge to recognize and manage co medical, psychosocial, and behavioral is
	Pediatrics practice is characterized by flexibility and adaptability. A good pediatrician has broad-based knowledge, strong critical thinking skills, and the flexibility to practice in a wide variety of settings and circumstances. Pediatricians have the skills to manage children and to recognize the need to refer as appropriate. Pediatricians provide consultation to others, formulate questions for consulting subspecialists, and co-manage children with chronic or complex physical and mental health problems.		Pediatrics practice is characterized by fl pediatrician has broad-based knowledge flexibility to practice in a wide variety of Pediatricians have the skills to manage refer as appropriate. Pediatricians provi questions for consulting subspecialists, complex physical and mental health pro
	Pediatricians are advocates for children. They have a strong presence within communities, where they promote health and health equity in ways that build public trust in the profession. In their interactions with others, they exhibit cultural humility and empathy. They are grounded in principles of science and social justice, advocate for underserved populations, and seek to eliminate disparities in care. They are collaborative leaders who lead by example and practice interprofessional team-based care. Pediatricians communicate effectively with patients, patients' families, treatment teams, communities, and		Pediatricians are advocates for children, communities, where they promote health public trust in the profession. In their inte cultural humility and empathy. They are social justice, advocate for underserved disparities in care. They are collaborativ practice interprofessional team-based ca effectively with patients, patients' familie
Int.B.	within health care systems.	[None]	within health care systems.
	As self-directed lifelong learners, pediatricians stay current with advanced and emerging technologies. They participate in scholarship, research, and investigation to keep the specialty current with these emerging technologies and to contribute to new innovations. They understand and collaboratively navigate the changing business aspects of medicine. Pediatricians utilize data and evidence-based practice to inform and advance patient care, resulting in high- value patient-centered care, continuous quality improvement, and equitable and ethical service delivery.		As self-directed lifelong learners, pediati emerging technologies. They participate investigation to keep the specialty curren and to contribute to new innovations. Th navigate the changing business aspects and evidence-based practice to inform a high-value patient-centered care, continu- equitable and ethical service delivery.
Int P. (Continued)	Pediatricians partner and connect with colleagues, team members, and patients, optimizing both their own and their teams' well-being. They find meaning, joy, and purpose by capably caring for patients and are equipped, educated, and trained to lead and manage teams. The pediatrician's coordination of care extends beyond the end of life, including grief and bereavement management. The discipline is characterized by a collaborative, compassionate, cognitive, scholarly, and relationship-oriented approach to	[None] (Continued)	Pediatricians partner and connect with or patients, optimizing both their own and to meaning, joy, and purpose by capably or educated, and trained to lead and mana coordination of care extends beyond the bereavement management. The disciplin compassionate, cognitive, scholarly, and
Int.B (Continued)	comprehensive patient care. Length of Educational Program	[None] - (Continued)	comprehensive patient care. Length of Educational Program
Int.C.	The educational program in pediatrics must be 36 months in length. (Core)	4.1.	The educational program in pediatrics m
l	Oversight	Section 1	Section 1: Oversight

ide comprehensive patient-centered r the growing and developing child from re. They care for the whole patient, having common childhood and adolescent issues.

flexibility and adaptability. A good ge, strong critical thinking skills, and the f settings and circumstances. e children and to recognize the need to vide consultation to others, formulate s, and co-manage children with chronic or roblems.

en. They have a strong presence within ofth and health equity in ways that build interactions with others, they exhibit re grounded in principles of science and ed populations, and seek to eliminate tive leaders who lead by example and care. Pediatricians communicate lies, treatment teams, communities, and

atricians stay current with advanced and te in scholarship, research, and rent with these emerging technologies They understand and collaboratively ets of medicine. Pediatricians utilize data and advance patient care, resulting in inuous quality improvement, and

colleagues, team members, and I their teams' well-being. They find caring for patients and are equipped, nage teams. The pediatrician's he end of life, including grief and line is characterized by a collaborative, nd relationship-oriented approach to

must be 36 months in length. (Core)

Requirement			
Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
	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 org ultimate financial and academic resp medical education, consistent with th 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 is ne most commonly utilized site of clinic primary clinical site.
I.A.1.	The program must be sponsored by one ACGME-accredited Sponsoring Institution.	1.1.	The program must be sponsored by o 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 organization or educational assignments/rotations
I.B.1.	The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)		The program, with approval of its Spo 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 agr and each participating site that gover program and the participating site pro
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 events of the PLA must be approved by the deater the the the test of
I.B.2.a).(2)	be approved by the designated institutional official (DIO). (Core)The program must monitor the clinical learning and working environment	1.3.b.	(Core) The program must monitor the clinica
I.B.3. I.B.3.a).	at all participating sites. (Core)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)	1.4.	at all participating sites. (Core) At each participating site there must by the program director as the site di resident education at that site, in coll (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 an participating sites routinely providing for all residents, of one month full tim the ACGME's Accreditation Data Syst
I.C.	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 S in practices that focus on mission-dri and retention of a diverse and inclusi present), faculty members, senior adr other relevant members of its academ
I.D.	Resources	1.8.	Resources The program, in partnership with its s the availability of adequate resources

rganization or entity that assumes the sponsibility for a program of graduate the ACGME Institutional

not a rotation site for the program, the ical activity for the program is the

one ACGME-accredited Sponsoring

on providing educational experiences ns for residents.

ponsoring Institution, must designate a

greement (PLA) between the program erns the relationship between the providing a required assignment. (Core)

every 10 years. <sup>(Core)</sup> designated institutional official (DIO).

cal learning and working environment

st be one faculty member, designated director, who is accountable for ollaboration with the program director.

any additions or deletions of ng an educational experience, required ime equivalent (FTE) or more through /stem (ADS). (Core)

#### on

s Sponsoring Institution, must engage driven, ongoing, systematic recruitment isive workforce of residents, fellows (if idministrative GME staff members, and emic community. (Core)

Sponsoring Institution, must ensure es for resident education. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
		-	Resources
I.D.1.	The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)	1.8.	The program, in partnership with its s the availability of adequate resources
I.D.1.a)	The program must provide a volume, variety, and complexity in diagnoses and age, of pediatric patients necessary for residents to achieve all of the required educational outcomes. (Core)	1.8.a.	The program must provide a volume, va age, of pediatric patients necessary for educational outcomes. (Core)
	There must be an emergency facility that specializes in the care of pediatric patients and that receives pediatric patients who have been transported via the		There must be an emergency facility that patients and that receives pediatric patients
I.D.1.b)	<ul> <li>emergency medical services system. (Core)</li> <li>Residents must have access to teaching and patient care workspace, including meeting rooms, computers, and medical and electronic resources to achieve all of the required educational outcomes. (Core)</li> </ul>	1.8.b. 1.8.c.	emergency medical services system. (C Residents must have access to teaching meeting rooms, computers, and medica of the required educational outcomes. (0
	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote		The program, in partnership with its S healthy and safe learning and working
I.D.2. I.D.2.a)	resident well-being and provide for: access to food while on duty; (Core)	1.9. 1.9.a.	resident well-being and provide for: access to food while on duty; (Core)
I.D.2.b)	safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)	1.9.b.	safe, quiet, clean, and private sleep/re for residents with proximity appropria
, I.D.2.c)	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	clean and private facilities for lactatio with proximity appropriate for safe pa
I.D.2.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures approp (Core)
I.D.2.e)	accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)	1.9.e.	accommodations for residents with d Sponsoring Institution's policy. (Core
I.D.3.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)	1.10.	Residents must have ready access to appropriate reference material in prin include access to electronic medical capabilities. (Core)
	Other Learners and Health Care Personnel The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the		Other Learners and Health Care Perso The presence of other learners and of but not limited to residents from othe and advanced practice providers, mu
I.E. II.	appointed residents' education. (Core) Personnel	1.11. Section 2	appointed residents' education. (Core Section 2: Personnel
II.A.	Program Director	2.1.	Program Director There must be one faculty member an authority and accountability for the or with all applicable program requireme
II.A.1.	There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)	2.1.	Program Director There must be one faculty member an authority and accountability for the o with all applicable program requireme
II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)	2.2.	The Sponsoring Institution's GMEC n director and must verify the program appointment. (Core)

#### nt Language

# Sponsoring Institution, must ensure es for resident education. (Core)

variety, and complexity in diagnoses and residents to achieve all of the required

nat specializes in the care of pediatric tients who have been transported via the Core)

ng and patient care workspace, including al and electronic resources to achieve all (Core)

Sponsoring Institution, must ensure ng environments that promote

/rest facilities available and accessible riate for safe patient care; (Core)

ion that have refrigeration capabilities, patient care; (Core)

priate to the participating site; and,

disabilities consistent with the re)

to specialty-specific and other int or electronic format. This must al literature databases with full text

#### sonnel

other health care personnel, including, ner programs, subspecialty fellows, nust not negatively impact the pre)

appointed as program director with overall program, including compliance nents. (Core)

appointed as program director with overall program, including compliance nents. (Core)

must approve a change in program n director's licensure and clinical

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	. Requiremen
II.A.1.b)	The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)	2.3.	The program must demonstrate reter length of time adequate to maintain o stability. (Core)
II.A.2.	The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)	2.4.	The program director and, as applica must be provided with support adeque based upon its size and configuration
	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. (Core)		Program leadership, in aggregate, must dedicated minimum time specified below may be time spent by the program direc director and one or more associate (or a
	Number of Approved Resident Positions: < 7   Minimum Support Required (FTE): 0.2		Number of Approved Resident Positions (FTE): 0.2
	Number of Approved Resident Positions: 7-10   Minimum Support Required (FTE): 0.4		Number of Approved Resident Positions (FTE): 0.4
	Number of Approved Resident Positions: 11-15   Minimum Support Required (FTE): 0.5		Number of Approved Resident Positions (FTE): 0.5
	Number of Approved Resident Positions: 16-20   Minimum Support Required (FTE): 0.6		Number of Approved Resident Positions (FTE): 0.6
	Number of Approved Resident Positions: 21-25   Minimum Support Required (FTE): 0.7		Number of Approved Resident Positions (FTE): 0.7
	Number of Approved Resident Positions: 26-30   Minimum Support Required (FTE): 0.8		Number of Approved Resident Positions (FTE): 0.8
	Number of Approved Resident Positions: 31-35   Minimum Support Required (FTE): 0.9		Number of Approved Resident Positions (FTE): 0.9
II.A.2.a)	Number of Approved Resident Positions: 36-40   Minimum Support Required (FTE): 1	2.4.a.	Number of Approved Resident Positions (FTE): 1

ention of the program director for a n continuity of leadership and program

cable, the program's leadership team, quate for administration of the program ion. (Core)

ust be provided with support equal to a low for administration of the program. This ector only or divided between the program r assistant) program directors. (Core)

- ons: < 7 | Minimum Support Required
- ons: 7-10 | Minimum Support Required
- ons: 11-15 | Minimum Support Required
- ons: 16-20 | Minimum Support Required
- ns: 21-25 | Minimum Support Required
- ons: 26-30 | Minimum Support Required
- ons: 31-35 | Minimum Support Required
- ons: 36-40 | Minimum Support Required

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
	Number of Approved Resident Positions: 41-45   Minimum Support Required (FTE): 1.1		Number of Approved Resident Positions (FTE): 1.1
	Number of Approved Resident Positions: 46-50   Minimum Support Required (FTE): 1.2		Number of Approved Resident Positions (FTE): 1.2
	Number of Approved Resident Positions: 51-55   Minimum Support Required (FTE): 1.3		Number of Approved Resident Positions (FTE): 1.3
	Number of Approved Resident Positions: 56-60   Minimum Support Required (FTE): 1.4		Number of Approved Resident Positions (FTE): 1.4
	Number of Approved Resident Positions: 61-65   Minimum Support Required (FTE): 1.5		Number of Approved Resident Positions (FTE): 1.5
	Number of Approved Resident Positions: 66-70   Minimum Support Required (FTE): 1.6		Number of Approved Resident Positions (FTE): 1.6
	Number of Approved Resident Positions: 71-75   Minimum Support Required (FTE): 1.7		Number of Approved Resident Positions (FTE): 1.7
	Number of Approved Resident Positions: 76-80   Minimum Support Required (FTE): 1.8		Number of Approved Resident Positions (FTE): 1.8
	Number of Approved Resident Positions: 81-85   Minimum Support Required (FTE): 1.9		Number of Approved Resident Positions (FTE): 1.9
	Number of Approved Resident Positions: 86-90   Minimum Support Required (FTE): 2		Number of Approved Resident Positions (FTE): 2
	Number of Approved Resident Positions: 91-95   Minimum Support Required (FTE): 2.1		Number of Approved Resident Positions (FTE): 2.1
	Number of Approved Resident Positions: 96-100   Minimum Support Required (FTE): 2.2		Number of Approved Resident Positions (FTE): 2.2
	Number of Approved Resident Positions: 101-105   Minimum Support Required (FTE): 2.3		Number of Approved Resident Positions (FTE): 2.3
II.A.2.a) - (Continued)	Number of Approved Resident Positions: 106-110   Minimum Support Required	2.4.a (Continued)	Number of Approved Resident Positions (FTE): 2.4

ons: 41-45 | Minimum Support Required ons: 46-50 | Minimum Support Required ons: 51-55 | Minimum Support Required ons: 56-60 | Minimum Support Required ons: 61-65 | Minimum Support Required ons: 66-70 | Minimum Support Required ons: 71-75 | Minimum Support Required ons: 76-80 | Minimum Support Required ons: 81-85 | Minimum Support Required ons: 86-90 | Minimum Support Required ons: 91-95 | Minimum Support Required ons: 96-100 | Minimum Support Required ons: 101-105 | Minimum Support Required

Requirement			
Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement Language
		•	
	Number of Approved Resident Positions: 111-115   Minimum Support Required (FTE): 2.5		Number of Approved Resident Positions: 111-115   Minimum Support Required (FTE): 2.5
	Number of Approved Resident Positions: 116-120   Minimum Support Required (FTE): 2.6		Number of Approved Resident Positions: 116-120   Minimum Support Required (FTE): 2.6
	Number of Approved Resident Positions: 121-125   Minimum Support Required (FTE): 2.7		Number of Approved Resident Positions: 121-125   Minimum Support Required (FTE): 2.7
	Number of Approved Resident Positions: 126-130   Minimum Support Required (FTE): 2.8		Number of Approved Resident Positions: 126-130   Minimum Support Required (FTE): 2.8
	Number of Approved Resident Positions: 131-135   Minimum Support Required (FTE): 2.9		Number of Approved Resident Positions: 131-135   Minimum Support Required (FTE): 2.9
	Number of Approved Resident Positions: 136-140   Minimum Support Required (FTE): 3		Number of Approved Resident Positions: 136-140   Minimum Support Required (FTE): 3
	Number of Approved Resident Positions: 141-145   Minimum Support Required (FTE): 3.1		Number of Approved Resident Positions: 141-145   Minimum Support Required (FTE): 3.1
	Number of Approved Resident Positions: 146-150   Minimum Support Required (FTE): 3.2		Number of Approved Resident Positions: 146-150   Minimum Support Required (FTE): 3.2
	Number of Approved Resident Positions: 151-155   Minimum Support Required (FTE): 3.3		Number of Approved Resident Positions: 151-155   Minimum Support Required (FTE): 3.3
	Number of Approved Resident Positions: 156-160   Minimum Support Required (FTE): 3.4		Number of Approved Resident Positions: 156-160   Minimum Support Required (FTE): 3.4
	Number of Approved Resident Positions: 161-165   Minimum Support Required (FTE): 3.5		Number of Approved Resident Positions: 161-165   Minimum Support Required (FTE): 3.5
	Number of Approved Resident Positions: 166-170   Minimum Support Required (FTE): 3.6		Number of Approved Resident Positions: 166-170   Minimum Support Required (FTE): 3.6
	Number of Approved Resident Positions: 171-175   Minimum Support Required (FTE): 3.7		Number of Approved Resident Positions: 171-175   Minimum Support Required (FTE): 3.7
	Number of Approved Resident Positions: 176-180   Minimum Support Required (FTE): 3.8		Number of Approved Resident Positions: 176-180   Minimum Support Required (FTE): 3.8
II.A.2.a) - (Continued)	Number of Approved Resident Positions: 181-185   Minimum Support Required (FTE): 3.9	2.4.a (Continued)	Number of Approved Resident Positions: 181-185   Minimum Support Required (FTE): 3.9
			Qualifications of the Program Director The program director must possess specialty expertise and at least three
			years of documented educational and/or administrative experience, or
II.A.3.	Qualifications of the program director:	2.5.	qualifications acceptable to the Review Committee. (Core)
			Qualifications of the Program Director
	must include specialty expertise and at least three years of documented		The program director must possess specialty expertise and at least three
A 3 a)	educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)	2.5.	years of documented educational and/or administrative experience, or
II.A.3.a)		2.0.	qualifications acceptable to the Review Committee. (Core)
	must include current certification in the specialty for which they are the		The program director must possess current certification in the specialty for which they are the program director by the American Board of
	program director by the American Board of Pediatrics (ABP) or by the		Pediatrics (ABP) or by the American Osteopathic Board of Pediatrics
	American Osteopathic Board of Pediatrics (AOBP), or specialty		(AOBP), or specialty qualifications that are acceptable to the Review
II.A.3.b)		2.5.a.	Committee. (Core)
	The program director must meet the requirements for either Maintenance of		The program director must meet the requirements for either Maintenance of
	Certification in pediatrics or a subspecialty of pediatrics through the ABP or	2.5.a.1.	Certification in pediatrics or a subspecialty of pediatrics through the ABP or
II.A.3.b).(1) II.A.3.c)	Osteopathic Continuous Certification through the AOBP. (Core) must include ongoing clinical activity. (Core)	2.5.a.1. <b>2.5.b.</b>	Osteopathic Continuous Certification through the AOBP. (Core) The program director must demonstrate ongoing clinical activity. (Core)
II.A.J.C/	Index melude ongoing chinical activity. (Core)	2.J.U.	The program unector must demonstrate ongoing clinical activity. (Core)

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	r Requiremen
	Program Director Responsibilities		
			Program Director Responsibilities
	The program director must have responsibility, authority, and		The program director must have resp
	accountability for: administration and operations; teaching and scholarly		accountability for: administration and
	activity; resident recruitment and selection, evaluation, and promotion of		activity; resident recruitment and sele
	residents, and disciplinary action; supervision of residents; and resident		residents, and disciplinary action; su
II.A.4.	education in the context of patient care. (Core)	2.6.	education in the context of patient ca
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 role r
	design and conduct the program in a fashion consistent with the needs of		The program director must design and
	the community, the mission(s) of the Sponsoring Institution, and the		consistent with the needs of the comr
II.A.4.a).(2)	mission(s) of the program; (Core)	2.6.b.	Sponsoring Institution, and the mission
			The program director must administer
l	administer and maintain a learning environment conducive to educating		environment conducive to educating
II.A.4.a).(3)	the residents in each of the ACGME Competency domains; (Core)	2.6.c.	Competency domains. (Core)
, 、 ,			The program director must have the a
	have the authority to approve or remove physicians and non-physicians		physicians and non-physicians as fac
	as faculty members at all participating sites, including the designation of		sites, including the designation of co
	core faculty members, and must develop and oversee a process to		develop and oversee a process to eva
II.A.4.a).(4)	evaluate candidates prior to approval; (Core)	2.6.d.	(Core)
	have the authority to remove residents from supervising interactions	2.0.0.	The program director must have the a
	and/or learning environments that do not meet the standards of the		
$   \wedge \langle A \rangle \rangle \langle F \rangle$	program; (Core)	2.6.e.	supervising interactions and/or learni the standards of the program. (Core)
II.A.4.a).(5)		2.0.0.	
	submit accurate and complete information required and requested by the	265	The program director must submit ac
II.A.4.a).(6)	DIO, GMEC, and ACGME; (Core)	2.6.f.	required and requested by the DIO, G
	provide a learning and working environment in which residents have the		The program director must provide a
	opportunity to raise concerns, report mistreatment, and provide feedback		which residents have the opportunity
	in a confidential manner as appropriate, without fear of intimidation or		mistreatment, and provide feedback in
II.A.4.a).(7)	retaliation; (Core)	2.6.g.	appropriate, without fear of intimidation
	ensure the program's compliance with the Sponsoring Institution's		The program director must ensure the
	policies and procedures related to grievances and due process, including		Sponsoring Institution's policies and
	when action is taken to suspend or dismiss, or not to promote or renew		and due process, including when acti
II.A.4.a).(8)	the appointment of a resident; (Core)	2.6.h.	not to promote or renew the appointm
			The program director must ensure the
	ensure the program's compliance with the Sponsoring Institution's		Sponsoring Institution's policies and
II.A.4.a).(9)	policies and procedures on employment and non-discrimination; (Core)	2.6.i.	discrimination. (Core)
	Residents must not be required to sign a non-competition guarantee or		Residents must not be required to sig
II.A.4.a).(9).(a)	restrictive covenant. (Core)	3.1.	restrictive covenant. (Core)
,			The program director must document
	document verification of education for all residents within 30 days of		residents within 30 days of completio
II.A.4.a).(10)	completion of or departure from the program; and, (Core)	2.6.j.	(Core)
	provide verification of an individual resident's education upon the		The program director must provide ve
II.A.4.a).(11)	resident's request, within 30 days; and (Core)	2.6.k.	education upon the resident's reques
	provide applicants who are offered an interview with information related		The program director must provide an
l	to the applicant's eligibility for the relevant specialty board		interview with information related to t
II.A.4.a).(12)	examination(s). (Core)	2.6.1.	relevant specialty board examination(

ponsibility, authority, and ad operations; teaching and scholarly lection, evaluation, and promotion of upervision of residents; and resident are. (Core)

e model of professionalism. (Core) and conduct the program in a fashion mmunity, the mission(s) of the sion(s) of the program. (Core) ter and maintain a learning g the residents in each of the ACGME

authority to approve or remove aculty members at all participating ore faculty members, and must valuate candidates prior to approval.

authority to remove residents from ning environments that do not meet )

ccurate and complete information GMEC, and ACGME. (Core)

a learning and working environment in ty to raise concerns, report in a confidential manner as tion or retaliation. (Core)

he program's compliance with the d procedures related to grievances tion is taken to suspend or dismiss, or ment of a resident. (Core)

he program's compliance with the dependent of the depende

ign a non-competition guarantee or

nt verification of education for all on of or departure from the program.

verification of an individual resident's est, within 30 days. (Core)

applicants who are offered an the applicant's eligibility for the n(s). (Core)

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	. Requiremer
	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		Faculty Faculty members are a foundational education – faculty members teach r Faculty members provide an importa and become practice-ready, ensuring quality of care. They are role models by demonstrating compassion, com
	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.		patient care, professionalism, and a d Faculty members experience the prior development of future colleagues. Th the opportunity to teach and model e scholarly approach to patient care, fa graduate medical education system, 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		Faculty members ensure that patient from a specialist in the field. They rea the patients, residents, community, a provide appropriate levels of supervi Faculty members create an effective professional manner and attending to
II.B.	themselves.	[None]	themselves.
	There must be a sufficient number of faculty members with competence to		There must be a sufficient number of
II.B.1.	instruct and supervise all residents. (Core)	2.7.	instruct and supervise all residents.
II.B.2.	Faculty members must:	[None]	Ecoulty Decreasibilities
II.B.2.a)	be role models of professionalism; (Core)	2.8.	Faculty Responsibilities Faculty members must be role model
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 demonstrate equitable, high-quality, cost-effective
1.0.2.0	demonstrate a strong interest in the education of residents, including	2.0.a.	Faculty members must demonstrate
II.B.2.c)	devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)	2.8.b.	residents, including devoting sufficie fulfill their supervisory and teaching
,	administer and maintain an educational environment conducive to		Faculty members must administer an
II.B.2.d)	educating residents; (Core)	2.8.c.	environment conducive to educating
	regularly participate in organized clinical discussions, rounds, journal		Faculty members must regularly part
II.B.2.e)	clubs, and conferences; and, (Core)	2.8.d.	discussions, rounds, journal clubs, a
	pursue faculty development designed to enhance their skills at least		Faculty members must pursue facult
II.B.2.f)	annually: (Core)	2.8.e.	their skills at least annually: (Core)
II.B.2.f).(1)	as educators and evaluators; (Detail) in quality improvement, eliminating health inequities, and patient safety;	2.8.e.1.	as educators and evaluators; (Detail) in quality improvement, eliminating h
II.B.2.f).(2)	(Detail)	2.8.e.2.	(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 reside
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 practic efforts. (Detail)

al element of graduate medical residents how to care for patients. tant bridge allowing residents to grow ng that patients receive the highest Is for future generations of physicians mmitment to excellence in teaching and a dedication to lifelong learning. ride and joy of fostering the growth and The care they provide is enhanced by I exemplary behavior. By employing a faculty members, through the n, improve the health of the individual

nts receive the level of care expected recognize and respond to the needs of , and institution. Faculty members rvision to promote patient safety. re learning environment by acting in a to the well-being of the residents and

of faculty members with competence to s. (Core)

lels of professionalism. (Core)

e commitment to the delivery of safe, ve, patient-centered care. (Core) e a strong interest in the education of cient time to the educational program to

g responsibilities. (Core)

and maintain an educational ng residents. (Core)

articipate in organized clinical , and conferences. (Core)

Ity development designed to enhance

health inequities, and patient safety;

dents' well-being; and, (Detail) ice-based learning and improvement

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	. Requiremen
	maintain awareness of and respond to patient volumes and acuity as they affect		Faculty members must maintain awaren and acuity as they affect the workload a
II.B.2.g)	the workload and well-being of the residents, and safety of the patients. (Core)	2.8.1.	safety of the patients. (Core) Faculty Qualifications
II.B.3.	Faculty Qualifications	2.9.	Faculty members must have appropri hold appropriate institutional appoint
	Faculty members must have appropriate qualifications in their field and		Faculty Qualifications Faculty members must have appropri
II.B.3.a)	hold appropriate institutional appointments. (Core)	2.9.	hold appropriate institutional appoint
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 Pediatrics or the American Osteopathic Board of Pediatrics or possess qualifications judged acceptable to the Review Committee. (Core)	2.10.	Physician faculty members must have by the American Board of Pediatrics o Pediatrics or possess qualifications ju Committee. (Core)
II.B.3.c)	For all pediatric subspecialty rotations there must be pediatric subspecialty physician faculty members who have current certification in their subspecialty by the ABP or the AOBP, or possess qualifications judged acceptable to the Review Committee. (Core)	2.10.a.	For all pediatric subspecialty rotations th physician faculty members who have cur the ABP or the AOBP, or possess qualifi Review Committee. (Core)
II.B.3.d)	Other physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess other qualifications judged acceptable to the Review Committee. (Core)	2.10.b.	Other physician faculty members must h specialty by the appropriate American Be member board or American Osteopathic possess other qualifications judged acce (Core)
II.B.4.	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 Core faculty members must have a sign supervision of residents and must de entire effort to resident education and component of their activities, teach, e feedback to residents. (Core)
II.B.4.a)	Core faculty members must complete the annual ACGME Faculty Survey. (Core)	2.11.a.	Core faculty members must complete (Core)
II.B.4.b)	In addition to the program director, there must be at least one ABP- or AOBP- certified core faculty member for every five approved resident positions in the program. (Core)	2.11.b.	In addition to the program director, there certified core faculty member for every fi program. (Core)
II.B.4.c)	At a minimum, the required core faculty members, in aggregate and excluding program leadership, must be provided with support equal to an average dedicated minimum of 0.1 FTE for educational and administrative responsibilities for the program that do not involve direct patient care. (Core)	2.11.c.	At a minimum, the required core faculty program leadership, must be provided w dedicated minimum of 0.1 FTE for educa responsibilities for the program that do n
11.0.4.0)		2.11.0.	Program Coordinator
II.C.	Program Coordinator	2.12.	There must be a program coordinator
II.C.1.	There must be a program coordinator. (Core)	2.12.	Program Coordinator There must be a program coordinator
II.C.2.	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 pro support adequate for administration of and configuration. (Core)

eness of and respond to patient volumes and well-being of the residents, and

oriate qualifications in their field and ntments. (Core)

riate qualifications in their field and ntments. (Core)

ve current certification in the specialty or the American Osteopathic Board of judged acceptable to the Review

there must be pediatric subspecialty current certification in their subspecialty by lifications judged acceptable to the

have current certification in their Board of Medical Specialties (ABMS) ic Association (AOA) certifying board, or ceptable to the Review Committee.

significant role in the education and levote a significant portion of their nd/or administration, and must, as a , evaluate, and provide formative

te the annual ACGME Faculty Survey.

re must be at least one ABP- or AOBPfive approved resident positions in the

y members, in aggregate and excluding with support equal to an average icational and administrative not involve direct patient care. (Core)

#### or. (Core)

or. (Core)

rovided with dedicated time and of the program based upon its size

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremer
Numerale			Kequiremen
	At a minimum, the program coordinator must be provided with the dedicated		At a minimum, the program coordinato
	time and support specified below for administration of the program: (Core)		time and support specified below for ac
	Number of Approved Resident Positions: < 7   Minimum FTE: 0.5		Number of Approved Resident Positior
	Number of Approved Resident Positions: 7-10   Minimum FTE: 0.7		Number of Approved Resident Positior
	Number of Approved Resident Positions: 11-15   Minimum FTE: 0.8		Number of Approved Resident Position
	Number of Approved Resident Positions: 16-20   Minimum FTE: 0.9		Number of Approved Resident Position
	Number of Approved Resident Positions: 21-25   Minimum FTE: 1		Number of Approved Resident Position
	Number of Approved Resident Positions: 26-30   Minimum FTE: 1.1		Number of Approved Resident Positior
	Number of Approved Resident Positions: 31-35   Minimum FTE: 1.2		Number of Approved Resident Position
	Number of Approved Resident Positions: 36-40   Minimum FTE: 1.3		Number of Approved Resident Position
	Number of Approved Resident Positions: 41-45   Minimum FTE: 1.4		Number of Approved Resident Position
	Number of Approved Resident Positions: 46-50   Minimum FTE: 1.5		Number of Approved Resident Position
	Number of Approved Resident Positions: 51-55   Minimum FTE: 1.6		Number of Approved Resident Position
	Number of Approved Resident Positions: 56-60   Minimum FTE: 1.7		Number of Approved Resident Position
	Number of Approved Resident Positions: 61-65   Minimum FTE: 1.8		Number of Approved Resident Position
	Number of Approved Resident Positions: 66-70   Minimum FTE: 1.9		Number of Approved Resident Position
	Number of Approved Resident Positions: 71-75   Minimum FTE: 2		Number of Approved Resident Position
	Number of Approved Resident Positions: 76-80   Minimum FTE: 2.1		Number of Approved Resident Position
	Number of Approved Resident Positions: 81-85   Minimum FTE: 2.2		Number of Approved Resident Position
	Number of Approved Resident Positions: 86-90   Minimum FTE: 2.3		Number of Approved Resident Position
	Number of Approved Resident Positions: 91-95   Minimum FTE: 2.4		Number of Approved Resident Position
	Number of Approved Resident Positions: 96-100   Minimum FTE: 2.5		Number of Approved Resident Position
	Number of Approved Resident Positions: 101-105   Minimum FTE: 2.6		Number of Approved Resident Position
	Number of Approved Resident Positions: 106-110   Minimum FTE: 2.7		Number of Approved Resident Position
	Number of Approved Resident Positions: 111-115   Minimum FTE: 2.8		Number of Approved Resident Position
I.C.2.a)	Number of Approved Resident Positions: 116-120   Minimum FTE: 2.9	2.12.b.	Number of Approved Resident Position
	Number of Approved Resident Positions: 121-125   Minimum FTE: 3		Number of Approved Resident Position
	Number of Approved Resident Positions: 126-130   Minimum FTE: 3.1		Number of Approved Resident Position
	Number of Approved Resident Positions: 131-135   Minimum FTE: 3.2		Number of Approved Resident Position
	Number of Approved Resident Positions: 136-140   Minimum FTE: 3.3		Number of Approved Resident Position
	Number of Approved Resident Positions: 141-145   Minimum FTE: 3.4		Number of Approved Resident Position
	Number of Approved Resident Positions: 146-150   Minimum FTE: 3.5		Number of Approved Resident Position
	Number of Approved Resident Positions: 151-155   Minimum FTE: 3.6		Number of Approved Resident Position
	Number of Approved Resident Positions: 156-160   Minimum FTE: 3.7		Number of Approved Resident Position
	Number of Approved Resident Positions: 161-165   Minimum FTE: 3.8		Number of Approved Resident Position
	Number of Approved Resident Positions: 166-170   Minimum FTE: 3.9		Number of Approved Resident Position
	Number of Approved Resident Positions: 171-175   Minimum FTE: 4		Number of Approved Resident Position Number of Approved Resident Position
I.C.2.a) - (Continued)	Number of Approved Resident Positions: 176-180   Minimum FTE: 4.1 Number of Approved Resident Positions: 181-185   Minimum FTE: 4.2	2.12.b (Continued)	Number of Approved Resident Position
, (	Other Program Personnel	(2	
	-		Other Program Personnel
	The program, in partnership with its Sponsoring Institution, must jointly		The program, in partnership with its
	ensure the availability of necessary personnel for the effective		ensure the availability of necessary
II.D.	administration of the program. (Core)	2.13.	administration of the program. (Core
III.	Resident Appointments	Section 3	Section 3: Resident Appointments

#### ent Language

or must be provided with the dedicated administration of the program: (Core) ons: < 7 | Minimum FTE: 0.5 ons: 7-10 | Minimum FTE: 0.7 ns: 11-15 | Minimum FTE: 0.8 ns: 16-20 | Minimum FTE: 0.9 ons: 21-25 | Minimum FTE: 1 ns: 26-30 | Minimum FTE: 1.1 ons: 31-35 | Minimum FTE: 1.2 ns: 36-40 | Minimum FTE: 1.3 ns: 41-45 | Minimum FTE: 1.4 ns: 46-50 | Minimum FTE: 1.5 ns: 51-55 | Minimum FTE: 1.6 ons: 56-60 | Minimum FTE: 1.7 ns: 61-65 | Minimum FTE: 1.8 ns: 66-70 | Minimum FTE: 1.9 ns: 71-75 | Minimum FTE: 2 ns: 76-80 | Minimum FTE: 2.1 ons: 81-85 | Minimum FTE: 2.2 ns: 86-90 | Minimum FTE: 2.3 ons: 91-95 | Minimum FTE: 2.4 ns: 96-100 | Minimum FTE: 2.5 ns: 101-105 | Minimum FTE: 2.6 ons: 106-110 | Minimum FTE: 2.7 ns: 111-115 | Minimum FTE: 2.8 ons: 116-120 | Minimum FTE: 2.9 ons: 121-125 | Minimum FTE: 3 ns: 126-130 | Minimum FTE: 3.1 ons: 131-135 | Minimum FTE: 3.2 ns: 136-140 | Minimum FTE: 3.3 ons: 141-145 | Minimum FTE: 3.4 ns: 146-150 | Minimum FTE: 3.5 ons: 151-155 | Minimum FTE: 3.6 ns: 156-160 | Minimum FTE: 3.7 ns: 161-165 | Minimum FTE: 3.8 ons: 166-170 | Minimum FTE: 3.9 ns: 171-175 | Minimum FTE: 4 ns: 176-180 | Minimum FTE: 4.1 ns: 181-185 | Minimum FTE: 4.2 Sponsoring Institution, must jointly

#### s Sponsoring Institution, must jointly personnel for the effective re)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
II.A.	Eligibility Requirements	3.2.	Eligibility Requirements An applicant must meet one of the fo for appointment to an ACGME-accred
III.A.1.	An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)	3.2.	Eligibility Requirements An applicant must meet one of the fo for appointment to an ACGME-accred
III.A.1.a)	graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)	3.2.a.	graduation from a medical school in t Liaison Committee on Medical Educa college of osteopathic medicine in the American Osteopathic Association Co Accreditation (AOACOCA); or, (Core)
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.	graduation from a medical school out meeting one of the following addition • holding a currently valid certificate f Foreign Medical Graduates (ECFMG) • holding a full and unrestricted licens States licensing jurisdiction in which located. (Core)
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.	graduation from a medical school out meeting one of the following addition • holding a currently valid certificate f Foreign Medical Graduates (ECFMG) • holding a full and unrestricted licens States licensing jurisdiction in which located. (Core)
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.	graduation from a medical school out meeting one of the following addition • holding a currently valid certificate f Foreign Medical Graduates (ECFMG) • holding a full and unrestricted licens States licensing jurisdiction in which located. (Core)

following qualifications to be eligible edited program: (Core)

following qualifications to be eligible edited program: (Core)

the United States, accredited by the cation (LCME) or graduation from a the United States, accredited by the Commission on Osteopathic College e)

utside of the United States, and onal qualifications: (Core)

e from the Educational Commission for ) prior to appointment; or, (Core)

ense to practice medicine in the United th the ACGME-accredited program is

utside of the United States, and onal qualifications: (Core)

e from the Educational Commission for ) prior to appointment; or, (Core)

nse to practice medicine in the United h the ACGME-accredited program is

utside of the United States, and onal qualifications: (Core)

e from the Educational Commission for ) prior to appointment; or, (Core)

ense to practice medicine in the United checked by the ACGME-accredited program is

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	Requiremen
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 clinica or transfer into ACGME-accredited re completed in ACGME-accredited resi residency programs, Royal College of (RCPSC)-accredited or College of Far accredited residency programs locate programs with ACGME International ( Accreditation. (Core)
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 receive ve competency in the required clinical fi ACGME-I Milestones evaluations from matriculation. (Core)
	Resident Complement		
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 appoin the Review Committee. (Core)
III.B.1.	The program should offer a minimum of four positions at each level of education. (Detail)	3.4.a.	The program should offer a minimum of education. (Detail)
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 verification and a summative competency-based acceptance of a transferring resident, matriculation. (Core)
	Educational Program The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless 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, 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		Section 4: Educational Program The ACGME accreditation system is of and innovation in graduate medical ed organizational affiliation, size, or loca The educational program must suppo knowledgeable, skillful physicians wh It is recognized programs may place of leadership, public health, etc. It is exp reflect the nuanced program-specific example, it is expected that a program scientists will have a different curricu
IV.	<i>community health.</i> Educational Components	Section 4	<i>community health.</i> Educational Components
IV.A.	The curriculum must contain the following educational components:	4.2.	The curriculum must contain the follo
	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		a set of program aims consistent with mission, the needs of the community capabilities of its graduates, which m
IV.A.1.	applicants, residents, and faculty members; (Core)	4.2.a.	applicants, residents, and faculty mer

al education required for initial entry residency programs must be sidency programs, AOA-approved of Physicians and Surgeons of Canada amily Physicians of Canada (CFPC)ited in Canada, or in residency I (ACGME-I) Advanced Specialty

verification of each resident's level of field using ACGME, CanMEDS, or om the prior training program upon

pint more residents than approved by

of four positions at each level of

n of previous educational experiences d performance evaluation prior to nt, and Milestones evaluations upon

designed to encourage excellence education regardless of the cation of the program.

port the development of who provide compassionate care.

e different emphasis on research, xpected that the program aims will ic goals for it and its graduates; for am aiming to prepare physicianculum from one focusing on

#### lowing educational components:

th the Sponsoring Institution's by it serves, and the desired distinctive must be made available to program embers; (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	. Requiremen
Numerais	competency-based goals and objectives for each educational experience		competency-based goals and objectiv
l	designed to promote progress on a trajectory to autonomous practice.		designed to promote progress on a tr
	These must be distributed, reviewed, and available to residents and		These must be distributed, reviewed,
IV.A.2.	faculty members; (Core)	4.2.b.	faculty members; (Core)
	delineation of resident responsibilities for patient care, progressive		delineation of resident responsibilities
IV.A.3.	responsibility for patient management, and graded supervision; (Core)	4.2.c.	responsibility for patient management
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured didactic a
IV.A.4.a)	Residents must be provided with protected time to participate in core didactic activities. (Core)	4.11.	Curriculum Organization and Residen Experiences Residents must be provided with prot didactic activities. (Core)
IV.A.5.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)	4.2.e.	formal educational activities that pron tools, and techniques. (Core)
IV.B.	ACGME Competencies	[None]	ACGME Competencies The Competencies provide a concept required domains for a trusted physic These Competencies are core to the p the specifics are further defined by ea trajectories in each of the Competence Milestones for each specialty.
IV.D.	· · · · · · · · · · · · · · · · · · ·		minestories for each specialty.
IV.B.1.	The program must integrate the following ACGME Competencies into the curriculum:	[None]	The program must integrate all ACGM
	Professionalism Residents must demonstrate a commitment to professionalism and an		ACGME Competencies – Professional Residents must demonstrate a comm adherence to ethical principles. (Core
IV.B.1.a)	adherence to ethical principles. (Core)	4.3.	Residents must demonstrate compete
,			ACGME Competencies – Professional Residents must demonstrate a comm adherence to ethical principles. (Core
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	Residents must demonstrate compete
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)	4.3.a.	compassion, integrity, and respect for
IV.B.1.a).(1).(b)	responsiveness to patient needs that supersedes self-interest; (Core)	4.3.b.	responsiveness to patient needs that
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 autono
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)	4.3.e.	accountability to patients, society, and
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 divers not limited to diversity in gender, age, national origin, socioeconomic status
	ability to recognize and develop a plan for one's own personal and		ability to recognize and develop a pla
IV.B.1.a).(1).(g)	professional well-being; and, (Core)	4.3.g.	professional well-being; and, (Core)
IV.B.1.a).(1).(h)	appropriately disclosing and addressing conflict or duality of interest. (Core)	4.3.h.	appropriately disclosing and addressi (Core)
IV.B.1.b)	Patient Care and Procedural Skills	[None]	

tives for each educational experience trajectory to autonomous practice. d, and available to residents and

ies for patient care, progressive ent, and graded supervision; (Core) c activities; and, (Core)

ent Experiences – Didactic and Clinical

otected time to participate in core

omote patient safety-related goals,

ptual framework describing the sician to enter autonomous practice. e practice of all physicians, although each specialty. The developmental ncies are articulated through the

ME Competencies into the curriculum.

alism

mitment to professionalism and an re)

etence in:

alism mitment to professionalism and an re)

etence in:

for others; (Core) at supersedes self-interest; (Core)

nomy; (Core)

and the profession; (Core)

rse patient populations, including but je, culture, race, religion, disabilities, us, and sexual orientation; (Core) lan for one's own personal and

ssing conflict or duality of interest.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
	Residents must be able to provide patient care that is patient- and family- centered, compassionate, equitable, appropriate, and effective for the		ACGME Competencies – Patient Care Residents must be able to provide pa centered, compassionate, equitable, a
IV.B.1.b).(1)	treatment of health problems and the promotion of health. (Core)	4.4.	treatment of health problems and the
IV.B.1.b).(1).(a)	Residents must demonstrate the ability to provide comprehensive medical care to infants, children, and adolescents, including: (Core)	4.4.a.	Residents must demonstrate the ability t to infants, children, and adolescents, inc
1V.D.1.D).(1).(a)	gathering essential and accurate information about the patient through history	4.4.a.	gathering essential and accurate information
IV.B.1.b).(1).(a).(i)	and physical examination; (Core)	4.4.a.1.	and physical examination; (Core)
	conducting health supervision, minor sick, and acute severe illness encounters,		conducting health supervision, minor sic
IV.B.1.b).(1).(a).(ii)	in addition to managing complex or chronic conditions; (Core)	4.4.a.2.	in addition to managing complex or chro
IV.B.1.b).(1).(a).(iii)	assessing growth and development from birth through the transition to adult practitioners; (Core)	4.4.a.3.	assessing growth and development from practitioners; (Core)
IV.B.1.b).(1).(a).(iv)	recognizing normal variations in growth, development, and wellness, and anticipating, preventing, and detecting disruptions in health and well-being; (Core)	4.4.a.4.	recognizing normal variations in growth, anticipating, preventing, and detecting d (Core)
IV.B.1.b).(1).(a).(v)	diagnosing and treating common conditions while recognizing, critically evaluating, and managing complexities; (Core)	4.4.a.5.	diagnosing and treating common conditi evaluating, and managing complexities;
	incorporating consideration of the impacts of social determinants of health and		incorporating consideration of the impac
IV.B.1.b).(1).(a).(vi)	advocating for social justice; (Core)	4.4.a.6.	advocating for social justice; (Core)
	prioritizing and organizing patient care which is safe, efficient, and effective,		prioritizing and organizing patient care w
IV.B.1.b).(1).(a).(vii)	taking into account severity of illness and patient volume; (Core)	4.4.a.7.	taking into account severity of illness and
IV.B.1.b).(1).(a).(viii)	identifying and managing common behavioral/mental health conditions of childhood; (Core)	4.4.a.8.	identifying and managing common beha childhood; (Core)
1V.D.1.D).(1).(a).(VIII)	providing medical care that addresses concerns of patients and their families;	4.4.a.o.	providing medical care that addresses of
IV.B.1.b).(1).(a).(ix)	(Core)	4.4.a.9.	(Core)
IV.B.1.b).(1).(a).(x)	providing medical care that addresses concerns of groups of patients; (Detail)	4.4.a.10.	providing medical care that addresses of
IV.B.1.b).(1).(a).(xi)	participating in real or simulated end-of-life care coordination and grief and bereavement management; (Detail)	4.4.a.11.	participating in real or simulated end-of-l bereavement management; (Detail)
IV.B.1.b).(1).(a).(xii)	using clinical reasoning based on interpretation of diagnostic information and problem solving, and adjusting management strategies to changing conditions and ambiguous situations; (Core)	4.4.a.12.	using clinical reasoning based on interpr problem solving, and adjusting manager and ambiguous situations; (Core)
IV.B.1.b).(1).(a).(xiii)	referring patients who require consultation, including those with surgical problems; and, (Core)	4.4.a.13.	referring patients who require consultation problems; and, (Core)
IV.B.1.b).(1).(a).(xiv)	resuscitating, stabilizing, and triaging patients to align care with severity of illness. (Core)	4.4.a.14.	resuscitating, stabilizing, and triaging pa illness. (Core)
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 – Procedural S perform all medical, diagnostic, and s essential for the area of practice. (Co
IV.B.1.b).(2).(a)	Residents must demonstrate competence in the following procedures: (Core)	4.5.a.	Residents must demonstrate competence
IV.B.1.b).(2).(a).(i)	bag-mask ventilation; (Core)	4.5.a.1.	bag-mask ventilation; (Core)
IV.B.1.b).(2).(a).(ii)	lumbar puncture; (Core)	4.5.a.2.	lumbar puncture; (Core)
IV.B.1.b).(2).(a).(iii)	neonatal delivery room stabilization; (Core)	4.5.a.3.	neonatal delivery room stabilization; (Co
IV.B.1.b).(2).(a).(iv)	peripheral intravenous catheter placement; and, (Core)	4.5.a.4.	peripheral intravenous catheter placeme
IV.B.1.b).(2).(a).(v)	simple laceration repair. (Core)	4.5.a.5.	simple laceration repair. (Core)
IV.B.1.b).(2).(b)	The program must provide instruction and opportunities for residents to perform procedures, as applicable to each resident's future career plans. (Core)	4.5.b.	The program must provide instruction ar procedures, as applicable to each reside

#### ent Language

re

patient care that is patient- and family-, appropriate, and effective for the e promotion of health. (Core)

y to provide comprehensive medical care ncluding: (Core)

mation about the patient through history

ick, and acute severe illness encounters, ronic conditions; (Core)

om birth through the transition to adult

h, development, and wellness, and disruptions in health and well-being;

itions while recognizing, critically s; (Core)

acts of social determinants of health and

which is safe, efficient, and effective, and patient volume; (Core)

navioral/mental health conditions of

concerns of patients and their families;

concerns of groups of patients; (Detail) f-life care coordination and grief and

pretation of diagnostic information and ement strategies to changing conditions

tion, including those with surgical

patients to align care with severity of

I Skills: Residents must be able to I surgical procedures considered ore)

nce in the following procedures: (Core)

Core)

nent; and, (Core)

and opportunities for residents to perform dent's future career plans. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
	Residents must complete training, maintain certification, and achieve		Residents must complete training, main
	competence in advanced life support skills in pediatrics and advanced life		competence in advanced life support ski
IV.B.1.b).(2).(c)	support skills in neonates. (Core)	4.5.c.	support skills in neonates. (Core)
	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	4.6	ACGME Competencies – Medical Kno Residents must demonstrate knowled biomedical, clinical, epidemiological, including scientific inquiry, as well as
IV.B.1.c)	patient care. (Core)	4.6.	patient care. (Core)
IV.B.1.c).(1)	Residents must demonstrate knowledge of central principles that drive exceptional health outcomes, high-value patient-centered care, continuous quality improvement, and equitable service delivery. (Core)	4.6.a.	Residents must demonstrate knowledge exceptional health outcomes, high-value quality improvement, and equitable servi
	Residents must demonstrate knowledge of the full spectrum of inpatient and		Residents must demonstrate knowledge
IV.B.1.c).(2)	outpatient care of well and sick infants, children, and adolescents through the transition to adult care. In addition to the diagnosis and management of common presentations, this includes but is not limited to knowledge of the following: (Core)	4.6.b.	outpatient care of well and sick infants, or transition to adult care. In addition to the common presentations, this includes but following: (Core)
IV.B.1.c).(2).(a)	the indications, contraindications, and complications for procedures; (Core)	4.6.b.1.	the indications, contraindications, and co
IV.B.1.c).(2).(b)	diagnosis and initial management of behavioral/mental health issues, including attention-deficit/hyperactivity disorder, anxiety, depression, and suicidality; (Core)	4.6.b.2.	diagnosis and initial management of beh attention-deficit/hyperactivity disorder, an (Core)
IV.B.1.c).(2).(c)	the application of information technologies and telehealth; (Core)	4.6.b.3.	the application of information technologic
IV.B.1.c).(2).(d)	the selection and interpretation of screening tools and tests; (Core)	4.6.b.4.	the selection and interpretation of screer
IV.B.1.c).(2).(e)	the components of requesting and providing patient consultation; (Core)	4.6.b.5.	the components of requesting and provid
IV.B.1.c).(2).(f)	the components of effective hand-over; (Core)	4.6.b.6.	the components of effective hand-over; (
IV.B.1.c).(2).(g)	the cost of lab tests, pharmaceuticals, and imaging; (Detail)	4.6.b.7.	the cost of lab tests, pharmaceuticals, ar
IV.B.1.c).(2).(h)	evidence-based guidelines that inform care; (Core)	4.6.b.8.	evidence-based guidelines that inform ca
	preventive health services for children and the components of normal		preventive health services for children a
IV.B.1.c).(2).(i)	childhood development; (Core)	4.6.b.9.	childhood development; (Core)
IV.B.1.c).(2).(j)	the components of the transition of care to adult practitioners; (Core)	4.6.b.10.	the components of the transition of care
IV.B.1.c).(2).(k)	the components of quality improvement and patient safety; (Core)	4.6.b.11.	the components of quality improvement
IV.B.1.c).(2).(I)	medication side effects and identification of adverse events; and, (Core)	4.6.b.12.	medication side effects and identification
$\mathbb{N}(\mathbb{P}(1, \mathbf{a}) / 2) / \mathbb{P}(1)$	explicit and implicit biases, and health care inequities related to gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and	1 6 h 12	explicit and implicit biases, and health ca culture, race, religion, disabilities, nation
IV.B.1.c).(2).(m)	sexual orientation. (Core)	4.6.b.13.	sexual orientation. (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-Bas Residents must demonstrate the abili care of patients, to appraise and assin continuously improve patient care bas lifelong learning. (Core)
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 compete deficiencies, and limits in one's know
IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)	4.7.b.	Residents must demonstrate compete improvement goals. (Core)

ntain certification, and achieve kills in pediatrics and advanced life

#### nowledge

edge of established and evolving I, and social-behavioral sciences, as the application of this knowledge to

ge of central principles that drive ue patient-centered care, continuous rvice delivery. (Core)

ge of the full spectrum of inpatient and , children, and adolescents through the ne diagnosis and management of out is not limited to knowledge of the

complications for procedures; (Core)

ehavioral/mental health issues, including anxiety, depression, and suicidality;

gies and telehealth; (Core)

ening tools and tests; (Core)

viding patient consultation; (Core)

; (Core)

and imaging; (Detail)

care; (Core)

and the components of normal

e to adult practitioners; (Core)

nt and patient safety; (Core)

on of adverse events; and, (Core)

care inequities related to gender, age, onal origin, socioeconomic status, and

ased Learning and Improvement ility to investigate and evaluate their similate scientific evidence, and to based on constant self-evaluation and

#### etence in identifying strengths, wledge and expertise. (Core) etence in setting learning and

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
IV.B.1.d).(1).(c)	identifying and performing appropriate learning activities; (Core)	4.7.c.	Residents must demonstrate compete appropriate learning activities. (Core)
IV.B.1.d).(1).(d)	systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)	4.7.d.	Residents must demonstrate competer practice using quality improvement m reducing health care disparities, and i of practice improvement. (Core)
IV.B.1.d).(1).(e)	incorporating feedback and formative evaluation into daily practice; and, (Core)	4.7.e.	Residents must demonstrate competer formative evaluation into daily practic
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 compete assimilating evidence from scientific s health problems. (Core)
IV.B.1.e) IV.B.1.e).(1)	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) Residents must demonstrate competence in	4.8. [None]	ACGME Competencies – Interpersona Residents must demonstrate interper- result in the effective exchange of infe patients, their families, and health pro
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 competer with patients and patients' families, as of socioeconomic circumstances, cul capabilities, learning to engage interp provide appropriate care to each patie
IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; (Core)	4.8.b.	Residents must demonstrate competer with physicians, other health profession (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 compete member or leader of a health care tea
IV.B.1.e).(1).(d)	educating patients, patients' families, students, other residents, and other health professionals; (Core)	4.8.d.	Residents must demonstrate competer families, students, other residents, an
IV.B.1.e).(1).(e)	acting in a consultative role to other physicians and health professionals; (Core)	4.8.e.	Residents must demonstrate competer to other physicians and health profes
IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible health care records, if applicable. (Core)	4.8.f.	Residents must demonstrate compete timely, and legible health care records
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 communicate to partner with them to assess their ca appropriate, end-of-life goals. (Core)
IV.B.1.e).(2).(a)	This must include:	[None]	Decidente must le sur exe enprenniste es
IV.B.1.e).(2).(a).(i)	age-appropriate communication strategies inclusive of risk assessment and anticipatory guidance; (Core)	4.8.g.1.	Residents must learn age-appropriate co assessment and anticipatory guidance. (
IV.B.1.e).(2).(a).(ii)	effective communication strategies with patients and patients' families who hesitate to accept recommended treatment, including vaccines; and, (Core)	4.8.g.2.	Residents must learn effective communi- patients' families who hesitate to accept vaccines. (Core)
IV.B.1.e).(2).(a).(iii)	effective communication strategies with patients and patients' families consistent with trauma-informed care. (Detail)	4.8.g.3.	Residents must learn effective communi- patients' families consistent with trauma-

etence in identifying and performing e)

etence in systematically analyzing methods, including activities aimed at d implementing changes with the goal

etence in incorporating feedback and tice. (Core)

etence in locating, appraising, and c studies related to their patients'

nal and Communication Skills ersonal and communication skills that nformation and collaboration with rofessionals. (Core)

etence in communicating effectively as appropriate, across a broad range ultural backgrounds, and language rpretive services as required to tient. <sup>(Core)</sup>

etence in communicating effectively sionals, and health-related agencies.

etence in working effectively as a eam or other professional group. (Core) etence in educating patients, patients' and other health professionals. (Core) etence in acting in a consultative role essionals. (Core)

etence in maintaining comprehensive, ds, if applicable. (Core)

ate with patients and patients' families care goals, including, when

communication strategies inclusive of risk . (Core)

nication strategies with patients and ot recommended treatment, including

nication strategies with patients and a-informed care. (Detail)

Requirement			
Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	Requirement
	Systems-based Practice		
			ACGME Competencies - Systems-Bas
	Residents must demonstrate an awareness of and responsiveness to the		Residents must demonstrate an aware
	larger context and system of health care, including the structural and		larger context and system of health ca
	social determinants of health, as well as the ability to call effectively on		social determinants of health, as well
IV.B.1.f).	other resources to provide optimal health care. (Core)	4.9.	other resources to provide optimal he
IV.B.1.f).(1)	Residents must demonstrate competence in:	[None]	
			Residents must demonstrate compete
	working effectively in various health care delivery settings and systems		health care delivery settings and system
IV.B.1.f).(1).(a)	relevant to their clinical specialty; (Core)	4.9.a.	specialty. <sup>(Core)</sup>
			Residents must demonstrate compete
	coordinating patient care across the health care continuum and beyond as	,	across the health care continuum and
IV.B.1.f).(1).(b)	relevant to their clinical specialty; (Core)	4.9.b.	specialty. <sup>(Core)</sup>
	advocating for quality patient care and optimal patient care systems;		Residents must demonstrate compete
IV.B.1.f).(1).(c)	(Core)	4.9.c.	care and optimal patient care systems
	participating in identifying system errors and implementing potential		Residents must demonstrate compete
IV.B.1.f).(1).(d)	systems solutions; (Core)	4.9.d.	system errors and implementing pote
	incorporating considerations of value, equity, cost awareness, delivery		Residents must demonstrate compete
	and payment, and risk-benefit analysis in patient and/or population-based		of value, equity, cost awareness, deliv
IV.B.1.f).(1).(e)	care as appropriate;(Core)	4.9.e.	analysis in patient and/or population-l
	understanding health care finances and its impact on individual patients'		Residents must demonstrate compete
IV.B.1.f).(1).(f)	health decisions; and, (Core)	4.9.f.	finances and its impact on individual
			Residents must demonstrate compete
	using tools and techniques that promote patient safety and disclosure of		that promote patient safety and disclo
IV.B.1.f).(1).(g)	patient safety events (real or simulated). (Detail)	4.9.g.	simulated). (Detail)
	advocating for the promotion of health and the prevention of disease and injury		Residents must demonstrate competenc
IV.B.1.f).(1).(h)	in populations. (Core)	4.9.i.	health and the prevention of disease and
	Residents must learn to advocate for patients within the health care		Residents must learn to advocate for
	system to achieve the patient's and patient's family's care goals,		system to achieve the patient's and pa
IV.B.1.f).(2)	including, when appropriate, end-of-life goals. (Core)	4.9.h.	including, when appropriate, end-of-li
IV.B.1.f).(3)	Residents must learn to collaborate with interprofessional colleagues. (Core)	4.9.j.	Residents must learn to collaborate with
	Residents must learn to collaborate with community organizations, including		Residents must learn to collaborate with
	schools and/or leaders in health care systems, in order to improve health care		schools and/or leaders in health care sys
IV.B.1.f).(4)	and well-being of patients. (Detail)	4.9.k.	and well-being of patients. (Detail)

ased Practice areness of and responsiveness to the care, including the structural and ell as the ability to call effectively on health care. (Core)

etence in working effectively in various stems relevant to their clinical

etence in coordinating patient care nd beyond as relevant to their clinical

etence in advocating for quality patient ns. (Core)

etence in participating in identifying tential systems solutions. (Core)

etence in incorporating considerations livery and payment, and risk-benefit n-based care as appropriate. (Core) etence in understanding health care

al patients' health decisions. (Core)

etence in using tools and techniques closure of patient safety events (real or

nce in advocating for the promotion of nd injury in populations. (Core)

or patients within the health care patient's family's care goals, -life goals. (Core)

th interprofessional colleagues. (Core)

th community organizations, including systems, in order to improve health care

Requirement			
Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	Requirement Language
			4.10. Curriculum Organization and Resident Experiences – Curriculum Structure 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)
			4.11. Curriculum Organization and Resident Experiences – Didactic and Clinical Experiences Residents must be provided with protected time to participate in core didactic activities. (Core)
IV.C.	Curriculum Organization and Resident Experiences	4.10 4.12.	4.12. Curriculum Organization and Resident Experiences – Pain Management 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)
	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 Resident Experiences – Curriculum Structure 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)
	Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback. <sup>(Core)</sup>	4.10.a.	Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback. <sup>(Core)</sup>
	Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Core)	4.10.b.	Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Core)
	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 Resident Experiences – Pain Management: 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)
IV.C.3.		4.11.a.	The program must have planned educational experiences. (Core)
	These experiences should be designed to complement and address any gaps in		These experiences should be designed to complement and address any gaps in
IV.C.3.a)		4.11.a.1.	the clinical experience. (Core)
	These experiences should include both independent study and group learning exercises necessary to ensure each resident acquires the knowledge, skills, and attitudes needed for the practice of pediatrics. (Detail)	4.11.a.2.	These experiences should include both independent study and group learning exercises necessary to ensure each resident acquires the knowledge, skills, and attitudes needed for the practice of pediatrics. (Detail)
	The program must establish requirements for resident and faculty member	4.11.a.3.	The program must establish requirements for resident and faculty member participation in educational experiences. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
IV.C.3.c).(1)	Participation by residents must be monitored. (Detail)	4.11.a.3.a.	Participation by residents must be monit
IV.C.3.c).(2)	Faculty members must provide oversight and participate as appropriate. (Detail)	4.11.a.3.b.	Faculty members must provide oversigh
IV.C.4.	The overall structure of the program must be organized as block and/or longitudinal experiences and must include: (Core)	4.10.c.	The overall structure of the program mus longitudinal experiences. (Core)
IV.C.4.a)		4.11.b.	There must be a minimum of 40 weeks of experiences, including elements of com- include a minimum of: (Core)
IV.C.4.a).(1)	<ul><li>8 weeks of general ambulatory pediatric clinic; (Core)</li><li>4 weeks of subspecialty outpatient experience, composed of no fewer than two</li></ul>	4.11.b.1.	8 weeks of general ambulatory pediatric 4 weeks of subspecialty outpatient expe
IV.C.4.a).(2)	subspecialties, in the first 24 months of the program; (Core)	4.11.b.2.	subspecialties, in the first 24 months of t
IV.C.4.a).(3)	4 weeks adolescent medicine; (Core)	4.11.b.3.	4 weeks adolescent medicine; (Core)
IV.C.4.a).(4)	4 weeks of mental health; (Core)	4.11.b.4.	4 weeks of mental health; (Core)
IV.C.4.a).(5)	4 weeks developmental-behavioral pediatrics; and, (Core)	4.11.b.5.	4 weeks developmental-behavioral pedia
IV.C.4.a).(6)	12 weeks of pediatric emergency medicine and acute illness. (Core)	4.11.b.6.	12 weeks of pediatric emergency medici
IV.C.4.a).(6).(a)	At least 8 of these weeks must be in the emergency department. (Core)	4.11.b.6.a.	At least 8 of these weeks must be in the
IV.C.4.b)	A minimum of 40 weeks of inpatient care experiences, to include: (Core)	4.11.c.	There must be 40 weeks of inpatient car
IV.C.4.b).(1)	24 weeks of inpatient medicine, with a minimum of 16 weeks of general pediatrics or pediatric hospital medicine service; (Core)	4.11.c.1.	24 weeks of inpatient medicine, with a medicine pediatrics or pediatric hospital medicine
IV.C.4.b).(1).(a)	The remaining time must be on the general pediatrics or pediatric hospital medicine service or other subspecialty services. No more than 4 weeks spent on a single subspecialty service, exclusive of pediatric hospital medicine; (Core)	4.11.c.1.a.	The remaining time must be on the gene medicine service or other subspecialty s on a single subspecialty service, exclusi
IV.C.4.b).(2)	12 weeks intensive care, to include a minimum of 4 weeks of pediatric intensive care unit and 4 weeks of neonatal intensive care unit; and, (Core)	4.11.c.2.	12 weeks intensive care, to include a mi care unit and 4 weeks of neonatal intensity.
IV.C.4.b).(3)	4 weeks of newborn nursery. (Core)	4.11.c.3.	4 weeks of newborn nursery. (Core)
IV.C.4.c)	A minimum of 40 weeks of an individualized curriculum. (Core)	4.11.d.	There must be a minimum of 40 weeks of
IV.C.4.c).(1)	The individualized curriculum must be determined by the learning needs and career plans of each resident and must be developed through the guidance of the program director or designee. (Core)	4.11.d.1.	The individualized curriculum must be de career plans of each resident and must l the program director or designee. (Core)
IV.C.4.c).(2)	Experiences must be distributed across the years of the educational program. (Core)	4.11.d.2.	Experiences must be distributed across (Core)
IV.C.4.c).(3)	There must be a minimum of 20 weeks of at least 5 additional pediatric subspecialty experiences beyond those used to meet the inpatient and outpatient requirements. Each subspecialty experience must be a minimum of 1 week and a maximum of 4 weeks in duration. (Core)	4.11.d.3.	There must be a minimum of 20 weeks of subspecialty experiences beyond those outpatient requirements. Each subspecia week and a maximum of 4 weeks in dura
	There must be a minimum of 20 weeks of elective clinical, scholarly, and/or		There must be a minimum of 20 weeks of
IV.C.4.c).(4)	other experiences. (Core)	4.11.d.4.	other experiences. (Core)
IV.C.4.d)	A longitudinal general pediatric outpatient experience in a setting that provides a medical home for the spectrum of pediatric patients, allowing residents to develop a continuous, long-term therapeutic relationship with a panel of pediatric patients which is in addition to the other required 40 weeks of ambulatory experiences. (Core)	4.11.e.	A longitudinal general pediatric outpatier medical home for the spectrum of pediat develop a continuous, long-term therape pediatric patients which is in addition to ambulatory experiences. (Core)
IV.C.4.d).(1)	There must be a longitudinal working experience between each resident and a single or core group of faculty members with expertise in primary care pediatrics and the principles of the medical home. (Core)	4.11.e.1.	There must be a longitudinal working ex single or core group of faculty members and the principles of the medical home.

nitored. (Detail)

ght and participate as appropriate. (Detail) just be organized as block and/or

s of primarily ambulatory care nmunity pediatrics and child advocacy, to

ic clinic; (Core)

perience, composed of no fewer than two f the program; (Core)

diatrics; and, (Core)

cine and acute illness. (Core)

e emergency department. (Core) are experiences, to include: (Core)

minimum of 16 weeks of general e service; (Core)

neral pediatrics or pediatric hospital services. No more than 4 weeks spent sive of pediatric hospital medicine. (Core) ninimum of 4 weeks of pediatric intensive nsive care unit; and, (Core)

of an individualized curriculum. (Core)

determined by the learning needs and t be developed through the guidance of e)

s the years of the educational program.

s of at least 5 additional pediatric e used to meet the inpatient and cialty experience must be a minimum of 1 uration. (Core)

s of elective clinical, scholarly, and/or

ent experience in a setting that provides a iatric patients, allowing residents to peutic relationship with a panel of o the other required 40 weeks of

experience between each resident and a rs with expertise in primary care pediatrics e. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
	There must be a minimum of 36 half-day sessions per year of a longitudinal	•	There must be a minimum of 36 half-day
IV.C.4.d).(2)	outpatient experience. (Core)	4.11.e.2.	outpatient experience. (Core)
IV.C.4.d).(2).(a)	These sessions must be distributed throughout the year. (Core)	4.11.e.2.a.	These sessions must be distributed through
IV.C.4.d).(2).(b)	The interval between these sessions should not exceed 8 weeks. (Core)	4.11.e.2.b.	The interval between these sessions sho
IV.C.4.e)	Residents must have experience in a supervisory role, under faculty guidance. (Core)	4.11.f.	Residents must have experience in a su (Core)
	This experience should occur for a minimum of 16 weeks during the final two		This experience should occur for a minim
IV.C.4.e).(1)	years in the program. (Core)	4.11.f.1.	years in the program. (Core)
	8 weeks of this experience should be on the inpatient general pediatrics or		8 weeks of this experience should be on
IV.C.4.e).(2)	pediatric hospital medicine service. (Detail)	4.11.f.2.	pediatric hospital medicine service. (Deta
	Scholarship Medicine is both an art and a science. The physician is a humanistic		Scholarship Medicine is both an art and a science.
	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.		scientist who cares for patients. This evaluate the literature, appropriately a practice lifelong learning. The progran environment that fosters the acquisiti participation in scholarly activities. So discovery, integration, application, an
IV.D.	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 focus for scholarship.	[None]	The ACGME recognizes the diversity of programs prepare physicians for a val scientists, and educators. It is expected will reflect its mission(s) and aims, and serves. For example, some programs activity on quality improvement, popul other programs might choose to utiliz research as the focus for scholarship.
			Program Responsibilities
IV.D.1.	Program Responsibilities	4.13.	The program must demonstrate evide with its mission(s) and aims. (Core)
IV.D.1.a)	The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)	4.13.	Program Responsibilities The program must demonstrate evide with its mission(s) and aims. (Core)
	The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in		The program, in partnership with its s adequate resources to facilitate reside
IV.D.1.b)	scholarly activities. (Core)	4.13.a.	scholarly activities. (Core)
IV.D.1.c)	The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)	4.13.b.	The program must advance residents scholarly approach to evidence-based

#### nt Language

ay sessions per year of a longitudinal

roughout the year. (Core)

hould not exceed 8 weeks. (Core)

supervisory role, under faculty guidance.

nimum of 16 weeks during the final two

on the inpatient general pediatrics or etail)

e. The physician is a humanistic is requires the ability to think critically, assimilate new knowledge, and ram and faculty must create an ition of such skills through resident Scholarly activities may include and teaching.

y of residencies and anticipates that variety of roles, including clinicians, cted that the program's scholarship and the needs of the community it as may concentrate their scholarly pulation health, and/or teaching, while lize more classic forms of biomedical ip.

dence of scholarly activities consistent

dence of scholarly activities consistent

s Sponsoring Institution, must allocate ident and faculty involvement in

ts' knowledge and practice of the ed patient care. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
			Faculty Scholarly Activity Among their scholarly activity, progra accomplishments in at least three of t
			<ul> <li>Research in basic science, education or population health</li> <li>Peer-reviewed grants</li> <li>Quality improvement and/or patients</li> <li>Systematic reviews, meta-analyses, textbooks, or case reports</li> <li>Creation of curricula, evaluation tool electronic educational materials</li> <li>Contribution to professional commit editorial boards</li> </ul>
IV.D.2.	Faculty Scholarly Activity	4.14.	Innovations in education
	Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)		Faculty Scholarly Activity Among their scholarly activity, progra accomplishments in at least three of t
	<ul> <li>Research in basic science, education, translational science, patient care, or population health</li> <li>Peer-reviewed grants</li> <li>Quality improvement and/or patient safety initiatives</li> <li>Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports</li> <li>Creation of curricula, evaluation tools, didactic educational activities, or</li> </ul>		<ul> <li>Research in basic science, educatio or population health</li> <li>Peer-reviewed grants</li> <li>Quality improvement and/or patient =</li> <li>Systematic reviews, meta-analyses, textbooks, or case reports</li> <li>Creation of curricula, evaluation too</li> </ul>
	<ul> <li>electronic educational materials</li> <li>Contribution to professional committees, educational organizations, or</li> </ul>		electronic educational materials • Contribution to professional commit
IV.D.2.a)	<ul> <li>editorial boards</li> <li>Innovations in education</li> </ul>	4.14.	editorial boards • Innovations in education
			The program must demonstrate disse and external to the program by the fol
			<ul> <li>faculty participation in grand rounds improvement presentations, podium p peer-reviewed print/electronic resource chapters, textbooks, webinars, service</li> </ul>
IV.D.2.b)	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:	4.14.a.	serving as a journal reviewer, journal (Outcome)

rams must demonstrate	
the following domains: (Core)	

ion, translational science, patient care,

nt safety initiatives s, review articles, chapters in medical

ools, didactic educational activities, or

nittees, educational organizations, or

rams must demonstrate f the following domains: (Core)

ion, translational science, patient care,

it safety initiatives s, review articles, chapters in medical

ools, didactic educational activities, or

nittees, educational organizations, or

semination of scholarly activity within following methods:

nds, posters, workshops, quality n presentations, grant leadership, nonurces, articles or publications, book rice on professional committees, or al editorial board member, or editor;

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	
			The program must demonstrate disse and external to the program by the fo
	faculty participation in grand rounds, posters, workshops, quality		<ul> <li>faculty participation in grand round</li> </ul>
	improvement presentations, podium presentations, grant leadership, non-		improvement presentations, podium
	peer-reviewed print/electronic resources, articles or publications, book		peer-reviewed print/electronic resour
	chapters, textbooks, webinars, service on professional committees, or		chapters, textbooks, webinars, servic
	serving as a journal reviewer, journal editorial board member, or editor;		serving as a journal reviewer, journal
IV.D.2.b).(1)	(Outcome)	4.14.a.	(Outcome)
	Desident Oskelerik, Astivity	4.45	Resident Scholarly Activity
IV.D.3.	Resident Scholarly Activity	4.15.	Residents must participate in scholar
	Desidents much verticingto in scholanskin (Osna)		Resident Scholarly Activity
IV.D.3.a)	Residents must participate in scholarship. (Core)	4.15.	Residents must participate in scholar
V.	Evaluation	Section 5	Section 5: Evaluation
			Resident Evaluation: Feedback and E
			Faculty members must directly obser
V.A.	Resident Evaluation	5.1.	feedback on resident performance du educational assignment. (Core)
<u>v.a.</u>		5.1.	Resident Evaluation: Feedback and E
			Faculty members must directly observed
			feedback on resident performance du
V.A.1.	Feedback and Evaluation	5.1.	educational assignment. (Core)
			Resident Evaluation: Feedback and E
	Faculty members must directly observe, evaluate, and frequently provide		Faculty members must directly observ
1	feedback on resident performance during each rotation or similar		feedback on resident performance du
V.A.1.a)	educational assignment. (Core)	5.1.	educational assignment. (Core)
	Evaluation must be documented at the completion of the assignment.		Evaluation must be documented at the
V.A.1.b)	(Core)	5.1.a.	(Core)
	For block rotations of greater than three months in duration, evaluation		For block rotations of greater than thr
V.A.1.b).(1)	must be documented at least every three months. (Core)	5.1.a.1.	must be documented at least every th
	Longitudinal experiences, such as continuity clinic in the context of other		Longitudinal experiences, such as co
	clinical responsibilities, must be evaluated at least every three months		clinical responsibilities, must be evalu
V.A.1.b).(2)	and at completion. (Core)	5.1.a.2.	and at completion. (Core)
	The program must provide an objective performance evaluation based on		The program must provide an objective
V.A.1.c)	the Competencies and the specialty-specific Milestones, and must: (Core)	5.1.b.	the Competencies and the specialty-s
	use multiple evaluators (e.g., faculty members, peers, patients, self, and		The program must use multiple evaluation
V.A.1.c).(1)	other professional staff members); and, (Core)	5.1.b.1.	patients, self, and other professional
	provide that information to the Clinical Competency Committee for its		The program must provide that inform
	synthesis of progressive resident performance and improvement toward		Committee for its synthesis of progre
V.A.1.c).(2)	unsupervised practice. (Core)	5.1.b.2.	improvement toward unsupervised pr
	The program director or their designee, with input from the Clinical	[Nene]	
V.A.1.d)	Competency Committee, must:	[None]	<b></b>
			The program director or their designe
l	meet with and review with each resident their documented semi-annual		Competency Committee, must meet w
$V \wedge 1 \rightarrow (1)$	evaluation of performance, including progress along the specialty-specific Milestones: (Core)		their documented semi-annual evalua
V.A.1.d).(1)	Milestones; (Core)	5.1.c.	progress along the specialty-specific

semination of scholarly activity within following methods:

ids, posters, workshops, quality n presentations, grant leadership, nonurces, articles or publications, book ice on professional committees, or al editorial board member, or editor;

arship. (Core)

arship. (Core)

Evaluation

erve, evaluate, and frequently provide during each rotation or similar

Evaluation

erve, evaluate, and frequently provide during each rotation or similar

Evaluation

erve, evaluate, and frequently provide during each rotation or similar

the completion of the assignment.

hree months in duration, evaluation three months. (Core)

continuity clinic in the context of other aluated at least every three months

tive performance evaluation based on -specific Milestones. <sup>(Core)</sup>

luators (e.g., faculty members, peers, al staff members). (Core)

rmation to the Clinical Competency ressive resident performance and practice. (Core)

nee, with input from the Clinical with and review with each resident uation of performance, including ic Milestones. (Core)

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	Requiremen
V.A.1.d).(2)	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 designer Competency Committee, must assist individualized learning plans to capit areas for growth. (Core)
V.A.1.d).(3)	develop plans for residents failing to progress, following institutional policies and procedures. (Core)	5.1.e.	The program director or their designed Competency Committee, must develop progress, following institutional polic
	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,		At least annually, there must be a sur that includes their readiness to progr
V.A.1.e)	if applicable. (Core)The evaluations of a resident's performance must be accessible for review	5.1.f.	applicable. (Core) The evaluations of a resident's perfor
V.A.1.f).	by the resident. (Core)	5.1.g.	by the resident. (Core)
V.A.1.g)	The evaluation process must be structured to mitigate implicit bias in resident evaluation. (Detail)	5.1.h.	The evaluation process must be structure evaluation. (Detail)
V.A.1.h)	The program must administer an in-training examination annually. (Core)	5.1.i.	The program must administer an in-train
V.A.2.	Final Evaluation	5.2.	Resident Evaluation: Final Evaluation The program director must provide a upon completion of the program. (Co
V.A.2.a)	The program director must provide a final evaluation for each resident upon completion of the program. (Core)	5.2.	Resident Evaluation: Final Evaluation The program director must provide a upon completion of the program. (Co
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)	5.2.a.	The specialty-specific Milestones, an specific Case Logs, must be used as engage in autonomous practice upon
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 par maintained by the institution, and mu resident in accordance with institutio
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 t knowledge, skills, and behaviors nec (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 we 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 me 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 Competen members of the program faculty, at le 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 other programs, or other health profe and experience with the program's re
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 at least semi-annually. (Core)

#### ent Language

nee, with input from the Clinical st residents in developing bitalize on their strengths and identify

nee, with input from the Clinical elop plans for residents failing to licies and procedures. (Core)

ummative evaluation of each resident gress to the next year of the program, if

formance must be accessible for review

tured to mitigate implicit bias in resident

aining examination annually. (Core)

on

a final evaluation for each resident Core)

on

a final evaluation for each resident Core)

and when applicable the specialtyas tools to ensure residents are able to on completion of the program. (Core)

part of the resident's permanent record nust be accessible for review by the tional policy. (Core)

t the resident has demonstrated the eccessary to enter autonomous practice.

with the resident upon completion of

must be appointed by the program

ency Committee must include three least one of whom is a core faculty

y members from the same program or fessionals who have extensive contact residents. (Core)

e must review all resident evaluations

Requirement			
Number - Roman	De multimente de la munera	Reformatted	
Numerals	Requirement Language	Requirement Number	
	determine each resident's progress on achievement of the specialty-	<b>5</b> 0 -1	The Clinical Competency Committee must determine each resident's
V.A.3.b).(2)	specific Milestones; and, (Core)	5.3.d.	progress on achievement of the specialty-specific Milestones. (Core)
			The Clinical Competency Committee must meet prior to the residents'
	meet prior to the residents' semi-annual evaluations and advise the		semi-annual evaluations and advise the program director regarding each
V.A.3.b).(3)	program director regarding each resident's progress. (Core)	5.3.e.	resident's progress. (Core)
			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.
V.B.	Faculty Evaluation	5.4.	(Core)
			Faculty Evaluation
	The program must have a process to evaluate each faculty member's		The program must have a process to evaluate each faculty member's
	performance as it relates to the educational program at least annually.		performance as it relates to the educational program at least annually.
V.B.1.	(Core)	5.4.	(Core)
	This evaluation must include a review of the faculty member's clinical		This evaluation must include a review of the faculty member's clinical
	teaching abilities, engagement with the educational program, participation		teaching abilities, engagement with the educational program, participation
	in faculty development related to their skills as an educator, clinical		in faculty development related to their skills as an educator, clinical
V.B.1.a)	performance, professionalism, and scholarly activities. (Core)	5.4.a.	performance, professionalism, and scholarly activities. (Core)
	This evaluation must include written, anonymous, and confidential		This evaluation must include written, anonymous, and confidential
V.B.1.b)	evaluations by the residents. (Core)	5.4.b.	evaluations by the residents. (Core)
	Faculty members must receive feedback on their evaluations at least		Faculty members must receive feedback on their evaluations at least
V.B.2.	annually. (Core)	5.4.c.	annually. (Core)
	Results of the faculty educational evaluations should be incorporated into		Results of the faculty educational evaluations should be incorporated into
V.B.3.	program-wide faculty development plans. (Core)	5.4.d.	program-wide faculty development plans. (Core)
			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
V.C.	Program Evaluation and Improvement	5.5.	program's continuous improvement process. (Core)
			Program Evaluation and Improvement
	The program director must appoint the Program Evaluation Committee to		The program director must appoint the Program Evaluation Committee to
	conduct and document the Annual Program Evaluation as part of the		conduct and document the Annual Program Evaluation as part of the
V.C.1.	program's continuous improvement process. (Core)	5.5.	program's continuous improvement process. (Core)
	The Program Evaluation Committee must be composed of at least two		The Program Evaluation Committee must be composed of at least two
	program faculty members, at least one of whom is a core faculty member,		program faculty members, at least one of whom is a core faculty member,
V.C.1.a)	and at least one resident. (Core)	5.5.a.	and at least one resident. (Core)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
	review of the program's self-determined goals and progress toward		Program Evaluation Committee responsibilities must include review of the
V.C.1.b).(1)		5.5.b.	program's self-determined goals and progress toward meeting them. <sup>(Core)</sup>
			Program Evaluation Committee responsibilities must include guiding
	guiding ongoing program improvement, including development of new		ongoing program improvement, including development of new goals,
V.C.1.b).(2)	goals, based upon outcomes; and, (Core)	5.5.c.	based upon outcomes. (Core)
			Program Evaluation Committee responsibilities must include review of the
	review of the current operating environment to identify strengths,		current operating environment to identify strengths, challenges,
	challenges, opportunities, and threats as related to the program's mission		opportunities, and threats as related to the program's mission and aims.
V.C.1.b).(3)		5.5.d.	(Core)
•		0.0.4.	

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
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 s prior Annual Program Evaluation(s), a evaluations of the program, and othe 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 n and aims, strengths, areas for improv
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, includistributed to and discussed with the teaching faculty, and be submitted to
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-St
	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 educa seek and achieve board certification. the educational program is the ultima
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 encoura take the certifying examination offere of Medical Specialties (ABMS) member Association (AOA) certifying board.
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 ABMS me board offer(s) an annual written exam program's aggregate pass rate of tho time must be higher than the bottom specialty. (Outcome)
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 ABMS me board offer(s) a biennial written exam program's aggregate pass rate of tho time must be higher than the bottom specialty. <sup>(Outcome)</sup>
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 ABMS me board offer(s) an annual oral exam, in program's aggregate pass rate of tho time must be higher than the bottom specialty. <sup>(Outcome)</sup>
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 ABMS me board offer(s) a biennial oral exam, in program's aggregate pass rate of tho time must be higher than the bottom specialty. <sup>(Outcome)</sup>
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 in a graduates over the time period speci an 80 percent pass rate will have met percentile rank of the program for pa

e should consider the outcomes from ), aggregate resident and faculty written her relevant data in its assessment of

e must evaluate the program's mission ovement, and threats. (Core)

cluding the action plan, must be he residents and the members of the to the DIO. (Core) Study and submit it to the DIO. (Core)

ication is to educate physicians who n. One measure of the effectiveness of nate pass rate.

Irage all eligible program graduates to red by the applicable American Board Iber board or American Osteopathic

member board and/or AOA certifying am, in the preceding three years, the nose taking the examination for the first n fifth percentile of programs in that

member board and/or AOA certifying am, in the preceding six years, the nose taking the examination for the first n fifth percentile of programs in that

member board and/or AOA certifying in the preceding three years, the nose taking the examination for the first n fifth percentile of programs in that

member board and/or AOA certifying in the preceding six years, the nose taking the examination for the first n fifth percentile of programs in that

n 5.6.a.-c., any program whose cified in the requirement have achieved let this requirement, no matter the bass rate in that specialty. <sup>(Outcome)</sup>

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	. Requiremen
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, board cohort of board-eligible residents that
	The Learning and Working Environment Residency education must occur in the context of a learning and working environment that emphasizes the following principles: • Excellence in the safety and quality of care rendered to patients by residents today • Excellence in the safety and quality of care rendered to patients by today's residents in their future practice		Section 6: The Learning and Working The Learning and Working Environme Residency education must occur in the environment that emphasizes the foll • Excellence in the safety and quality residents today • Excellence in the safety and quality today's residents in their future pract • Excellence in professionalism
VI	<ul> <li>Appreciation for the privilege of caring for patients</li> <li>Commitment to the well-being of the students, residents, faculty members, and all members of the health care team</li> </ul>	Section 6	<ul> <li>Appreciation for the privilege of cars</li> <li>Commitment to the well-being of the members, and all members of the heat</li> </ul>
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 continuou and a willingness to transparently dea organization has formal mechanisms attitudes of its personnel toward safe improvement.
	The program, its faculty, residents, and fellows must actively participate in		The program, its faculty, residents, an
VI.A.1.a).(1).(a) 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. Residents, fellows, faculty members, and other clinical staff members	[None]	patient safety systems and contribute Patient Safety Events Reporting, investigation, and follow-u unsafe conditions are pivotal mechan and are essential for the success of a and experiential learning are essentia the ability to identify causes and insti- changes to ameliorate patient safety
VI.A.1.a).(2).(a)	must:	[None]	

rd certification status annually for the hat graduated seven years earlier. <sup>(Core)</sup>

#### ng Environment

ment

the context of a learning and working ollowing principles:

ty of care rendered to patients by

ty of care rendered to patients by octice

aring for patients

the students, residents, faculty realth care team

ous identification of vulnerabilities deal with them. An effective ns to assess the knowledge, skills, and afety in order to identify areas for

and fellows must actively participate in ute to a culture of safety. (Core)

v-up of safety events, near misses, and panisms for improving patient safety, f any patient safety program. Feedback tial to developing true competence in stitute sustainable systems-based ty vulnerabilities.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
VI.A.1.a).(2).(a).(i)	know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)	6.2.	Residents, fellows, faculty members, must know their responsibilities in re unsafe conditions at the clinical site, (Core)
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 members, must be provided with summary infor 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)		Residents must participate as team m interprofessional clinical patient safet such as root cause analyses or other well as formulation and implementation
	Quality Metrics Access to data is essential to prioritizing activities for care improvement		Quality Metrics Access to data is essential to prioritiz
VI.A.1.a).(3) VI.A.1.a).(3).(a)	<ul> <li>and evaluating success of improvement efforts.</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.	and evaluating success of improvement Residents and faculty members must benchmarks related to their patient po
VI.A.2.	Supervision and Accountability	[None]	Supervision and Accountability Although the attending physician is un the patient, every physician shares in accountability for their efforts in the p programs, in partnership with their Sp communicate, and monitor a structure accountability as it relates to the supe Supervision in the setting of graduate and effective care to patients; ensures skills, knowledge, and attitudes requin practice of medicine; and establishes professional growth.
	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 physician is un the patient, every physician shares in accountability for their efforts in the p programs, in partnership with their Sp communicate, and monitor a structure accountability as it relates to the supe
VI.A.2.a)	Supervision in the setting of graduate medical education provides 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.	[None]	Supervision in the setting of graduate and effective care to patients; ensures skills, knowledge, and attitudes requi practice of medicine; and establishes professional growth.

s, and other clinical staff members reporting patient safety events and e, including how to report such events.

s, and other clinical staff members prmation of their institution's patient

members in real and/or simulated fety and quality improvement activities, er activities that include analysis, as tion of actions. (Core)

tizing activities for care improvement nent efforts.

st receive data on quality metrics and populations. (Core)

ultimately responsible for the care of in the responsibility and provision of care. Effective Sponsoring Institutions, define, widely ured chain of responsibility and pervision of all patient care.

te medical education provides safe res each resident's development of the uired to enter the unsupervised es a foundation for continued

ultimately responsible for the care of in the responsibility and provision of care. Effective Sponsoring Institutions, define, widely ured chain of responsibility and pervision of all patient care.

te medical education provides safe res each resident's development of the uired to enter the unsupervised es a foundation for continued

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	Requiremen
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 must respective roles in that patient's care This information must be available to members of the health care team, and
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 must respective roles in that patient's care This information must be available to members of the health care team, and
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 that it place for all residents is based on eac ability, as well as patient complexity a exercised through a variety of method (Core)
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 resident supe authority and responsibility, the prog classification of supervision.
VI.A.2.b).(1)	Direct Supervision	6.7.	Direct Supervision The supervising physician is physica the key portions of the patient interac The supervising physician and/or pat the resident and the supervising physician patient care through appropriate television
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 physica the key portions of the patient interac The supervising physician and/or pat the resident and the supervising physician patient care through appropriate television
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 sup the above definition. (Core)
VI.A.2.b).(1).(a).(i).(a)	After the assessment of a PGY-1 resident's performance, the program may approve the resident's ability to be supervised indirectly. (Core)	6.7.a.1.	After the assessment of a PGY-1 reside approve the resident's ability to be supe
	the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the		Direct Supervision The supervising physician is physica the key portions of the patient interac The supervising physician and/or pat the resident and the supervising physical
VI.A.2.b).(1).(b)	patient care through appropriate telecommunication technology.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.	6.7.	patient care through appropriate telev Indirect Supervision The supervising physician is not prov or audio supervision but is immediate guidance and is available to provide a
VI.A.2.b).(2)	Janher Alainir	[None]	guidance and is available to provide a

#### ent Language

ist inform each patient of their re when providing direct patient care. to residents, faculty members, other and patients. (Core)

ist inform each patient of their re when providing direct patient care. to residents, faculty members, other and patients. (Core)

It the appropriate level of supervision in each resident's level of training and y and acuity. Supervision may be nods, as appropriate to the situation.

*pervision while providing for graded ogram must use the following* 

cally present with the resident during raction.

eatient is not physically present with aysician is concurrently monitoring the lecommunication technology.

cally present with the resident during action.

atient is not physically present with hysician is concurrently monitoring the lecommunication technology.

upervised directly, only as described in

dent's performance, the program may pervised indirectly. (Core)

cally present with the resident during raction.

eatient is not physically present with hysician is concurrently monitoring the lecommunication technology.

roviding physical or concurrent visual ately available to the resident for e appropriate direct supervision.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
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 available procedures/encounters with feedback
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 physi 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 authority independence, and a supervisory role resident must be assigned by the pro- (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 evaluate e specific criteria, guided by the Milesto
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 supe portions of care to residents based or skills of each resident. (Core)
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 should ser residents in recognition of their progr the needs of each patient and the skill (Detail)
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 circ residents must communicate with the (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 limits of circumstances under which the reside conditional independence. (Outcome)
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 assignments mus the knowledge and skills of each resid the appropriate level of patient care a
VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with their Sp residents and faculty members conce responsibilities of physicians, includi to be appropriately rested and fit to pr 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 their Sp residents and faculty members conce responsibilities of physicians, includin to be appropriately rested and fit to pr 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 programeter excessive reliance on residents to full
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the program care responsibilities. (Core)

ble to provide review of ck provided after care is delivered. sical presence of a supervising

ty and responsibility, conditional le in patient care delegated to each ogram director and faculty members.

e each resident's abilities based on stones. (Core)

pervising physicians must delegate on the needs of the patient and the

serve in a supervisory role to junior gress toward independence, based on kills of the individual resident or fellow.

rcumstances and events in which ne supervising faculty member(s).

of their scope of authority, and the dent is permitted to act with e)

ust be of sufficient duration to assess sident and to delegate to the resident authority and responsibility. (Core)

Sponsoring Institutions, must educate cerning the professional and ethical ding but not limited to their obligation provide the care required by their

Sponsoring Institutions, must educate cerning the professional and ethical ding but not limited to their obligation provide the care required by their

am must be accomplished without ulfill non-physician obligations. <sup>(Core)</sup> ram must ensure manageable patient

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
VI.B.2.b).(1)	Patient care responsibilities must be structured to support the well-being of the entire care team while supporting clinical, scholarly, personal, and professional development. (Core)	6.12.b.1.	Patient care responsibilities must be str entire care team while supporting clinica development. (Core)
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 progra the meaning that each resident finds physician, including protecting time administrative support, promoting pr flexibility, and enhancing profession
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 partnership provide a culture of professionalism personal responsibility. (Core)
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 must their personal role in the safety and v care, including the ability to report ur (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 their S a professional, equitable, respectful, psychologically safe and that is free f forms of harassment, mistreatment, a residents, faculty, and staff. (Core)
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 their S process for education of residents ar behavior and a confidential process f addressing such concerns. (Core)
	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 physic development of the competent, caring proactive attention to life inside and o requires that physicians retain the joy own real-life stresses. Self-care and r members of the health care team are professionalism; they are also skills a nurtured in the context of other aspec
VI.C.	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 skills and attitudes needed to thrive throughout their careers.	[None]	Residents and faculty members are a Programs, in partnership with their S same responsibility to address well-k competence. Physicians and all mem responsibility for the well-being of ea clinical learning environment models prepares residents with the skills and throughout their careers.
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program, in 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 intensit impacts resident well-being; (Core)

#### ent Language

tructured to support the well-being of the cal, scholarly, personal, and professional

ram must include efforts to enhance ls in the experience of being a e with patients, providing progressive independence and nal relationships. (Core)

p with the Sponsoring Institution, must n that supports patient safety and

ist demonstrate an understanding of I welfare of patients entrusted to their unsafe conditions and safety events.

Sponsoring Institutions, must provide II, and civil environment that is e from discrimination, sexual and other a buse, or coercion of students,

Sponsoring Institutions, should have a and faculty regarding unprofessional s for reporting, investigating, and

sical well-being are critical in the ing, and resilient physician and require d outside of medicine. Well-being joy in medicine while managing their d responsibility to support other re important components of s that must be modeled, learned, and bects of residency training.

e at risk for burnout and depression. Sponsoring Institutions, have the I-being as other aspects of resident embers of the health care team share each other. A positive culture in a els constructive behaviors, and nd attitudes needed to thrive

n partnership with the Sponsoring

sity, and work compression that

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	-
	evaluating workplace safety data and addressing the safety of residents		evaluating workplace safety data and
VI.C.1.b)	and faculty members; (Core)	6.13.b.	and faculty members; (Core)
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 member well-being; and, (Core)
<u>vi.c.</u> 1.c <i>j</i>	Residents must be given the opportunity to attend medical, mental health,	0.13.0.	Residents must be given the opportu
	and dental care appointments, including those scheduled during their		and dental care appointments, includ
VI.C.1.c).(1)	working hours. (Core)	6.13.c.1.	working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty me
	identification of the symptoms of burnout, depression, and substance use		identification of the symptoms of bur
	disorders, suicidal ideation, or potential for violence, including means to		disorders, suicidal ideation, or potent
VI.C.1.d).(1)	assist those who experience these conditions; (Core)	6.13.d.1.	assist those who experience these co
	recognition of these symptoms in themselves and how to seek		recognition of these symptoms in the
VI.C.1.d).(2)	appropriate care; and, (Core)	6.13.d.2.	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-so
	providing access to confidential, affordable mental health assessment,		providing access to confidential, affo
	counseling, and treatment, including access to urgent and emergent care		counseling, and treatment, including
VI.C.1.e)	24 hours a day, seven days a week. (Core)	6.13.e.	24 hours a day, seven days a week. (C
	There are circumstances in which residents may be unable to attend work,		There are circumstances in which res
	including but not limited to fatigue, illness, family emergencies, and		including but not limited to fatigue, ill
	medical, parental, or caregiver leave. Each program must allow an		medical, parental, or caregiver leave.
VI.C.2.	appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)	6.14.	appropriate length of absence for res care responsibilities. (Core)
VI.C.Z.	The program must have policies and procedures in place to ensure	0.14.	The program must have policies and
VI.C.2.a)		6.14.a.	coverage of patient care and ensure of
1.0.2.0)	These policies must be implemented without fear of negative		These policies must be implemented
	consequences for the resident who is or was unable to provide the clinical		consequences for the resident who is
VI.C.2.b)	work. (Core)	6.14.b.	work. (Core)
			Fatigue Mitigation
			Programs must educate all residents
1			of the signs of fatigue and sleep depr
VI.D.	Fatigue Mitigation	6.15.	fatigue mitigation processes. (Detail)
			Fatigue Mitigation
	Programs must educate all residents and faculty members in recognition		Programs must educate all residents
	of the signs of fatigue and sleep deprivation, alertness management, and		of the signs of fatigue and sleep depr
VI.D.1.		6.15.	fatigue mitigation processes. (Detail)
	The program, in partnership with its Sponsoring Institution, must ensure		The program, in partnership with its S
	adequate sleep facilities and safe transportation options for residents who		adequate sleep facilities and safe tran
VI.D.2. VI.E.	may be too fatigued to safely return home. (Core) Clinical Responsibilities, Teamwork, and Transitions of Care	6.16. [None]	may be too fatigued to safely return h
VI.C.			Olimiaal Deeneneikilikkee
	Clinical Responsibilities The clinical responsibilities for each resident must be based on PGY level,		Clinical Responsibilities The clinical responsibilities for each r
	patient safety, resident ability, severity and complexity of patient		patient safety, resident ability, severit
VI.E.1.	illness/condition, and available support services. (Core)	6.17.	illness/condition, and available suppo
	The program director must have the authority and responsibility to set		The program director must have the aut
l	appropriate clinical responsibilities for each resident based on the PGY level,		appropriate clinical responsibilities for ea
l	patient safety, resident education, severity and complexity of patient		patient safety, resident education, sever
VI.E.1.a)	illness/condition, and available support services. (Core)	6.17.a.	illness/condition, and available support s

ent Language

nd addressing the safety of residents

age optimal resident and faculty

tunity to attend medical, mental health, uding those scheduled during their

nembers in:

urnout, depression, and substance use ntial for violence, including means to conditions; (Core)

nemselves and how to seek

-screening. (Core)

fordable mental health assessment, ig access to urgent and emergent care (Core)

esidents may be unable to attend work, illness, family emergencies, and e. Each program must allow an esidents unable to perform their patient

d procedures in place to ensure e continuity of patient care. (Core) ed without fear of negative

is or was unable to provide the clinical

ts and faculty members in recognition privation, alertness management, and il)

ts and faculty members in recognition privation, alertness management, and il)

Sponsoring Institution, must ensure ansportation options for residents who home. (Core)

h resident must be based on PGY level, rity and complexity of patient port services. (Core)

uthority and responsibility to set each resident based on the PGY level, rerity and complexity of patient rt services. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
	Residents must be assigned an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which may		Residents must be assigned an appropr experiences do not meet educational ne an inappropriate reliance on residents fo
VI.E.1.b)	jeopardize the educational experience. (Core)	6.17.b.	jeopardize the educational experience.
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 in a communication and promotes safe, in the specialty and larger health system
	Transitions of Care	6 40	Transitions of Care Programs must design clinical assign
VI.E.3.	Transitions of Care Programs must design clinical assignments to optimize transitions in	6.19.	patient care, including their safety, fro Transitions of Care Programs must design clinical assign
VI.E.3.a) VI.E.3.b)	patient care, including their safety, frequency, and structure. (Core)Programs, in partnership with their Sponsoring Institutions, must ensureand monitor effective, structured hand-off processes to facilitate bothcontinuity of care and patient safety. (Core)	6.19. 6.19.a.	patient care, including their safety, fro Programs, in partnership with their S and monitor effective, structured han continuity of care and patient safety.
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 residents with team members in the hand-off pr
VI.F.	Clinical Experience and Education <i>Programs, in partnership with their Sponsoring Institutions, must design</i> <i>an effective program structure that is configured to provide residents with</i> <i>educational and clinical experience opportunities, as well as reasonable</i> <i>opportunities for rest and personal activities.</i>	[None]	Clinical Experience and Education Programs, in partnership with their S an effective program structure that is educational and clinical experience of opportunities for rest and personal ad
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)	6.20.	Maximum Hours of Clinical and Educ Clinical and educational work hours r hours per week, averaged over a four house clinical and educational activit and all moonlighting. (Core)
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	Mandatory Time Free of Clinical Work Residents should have eight hours of and education periods. (Detail)
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 Work Residents should have eight hours of and education periods. (Detail)
VI.F.2.b)	Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)	6.21.a.	Residents must have at least 14 hour after 24 hours of in-house call. (Core)
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). Athome call cannot be assigned on these free days. (Core)	6.21.b.	Residents must be scheduled for a m clinical work and required education home call cannot be assigned on the
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	Maximum Clinical Work and Education Clinical and educational work periods hours of continuous scheduled clinic

ent Language
priate patient load. Insufficient patient needs; an excessive patient load suggests for service obligations, which may
. (Core)
an environment that maximizes interprofessional, team-based care in em. (Core)
gnments to optimize transitions in frequency, and structure. (Core)
gnments to optimize transitions in frequency, and structure. (Core)
Sponsoring Institutions, must ensure and-off processes to facilitate both /. (Core)
ts are competent in communicating process. (Outcome)
Sponsoring Institutions, must design is configured to provide residents with opportunities, as well as reasonable activities.
<i></i>
icational Work per Week s must be limited to no more than 80
ur-week period, inclusive of all in-
vities, clinical work done from home,
rk and Education off between scheduled clinical work
rk and Education
off between scheduled clinical work
urs free of clinical work and education e)
minimum of one day in seven free of
n (when averaged over four weeks). At- lese free days. (Core)
ion Period Length
ds for residents must not exceed 24

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	<b>Requirement Number</b>	Requiremen
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 Educatio Clinical and educational work periods hours of continuous scheduled clinic
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 time ma patient safety, such as providing effe resident education. Additional patient assigned to a resident during this tim
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	Clinical and Educational Work Hour E In rare circumstances, after handing or resident, on their own initiative, may clinical site in the following circumsta a single severely ill or unstable patier needs of a patient or patient's family; events. (Detail)
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 Hour E In rare circumstances, after handing or resident, on their own initiative, may clinical site in the following circumsta a single severely ill or unstable patien needs of a patient or patient's family; events. (Detail)
<u></u>	These additional hours of care or education must be counted toward the		These additional hours of care or edu
VI.F.4.b)	80-hour weekly limit. (Detail)	6.23.a.	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 rotati percent or a maximum of 88 clinical a individual programs based on a soun
VI.F.4.c)	The Review Committee for Pediatrics will not consider requests for exceptions to the 80-hour limit to residents' work week.	6.24.	The Review Committee for Pediatrics wi to the 80-hour limit to residents' work we
VI.F.5.	Moonlighting	6.25.	Moonlighting Moonlighting must not interfere with the goals and objectives of the educa interfere with the resident's fitness fo safety. (Core)
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 with the goals and objectives of the educa interfere with the resident's fitness fo safety. (Core)
	Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour	6.25.a.	Time spent by residents in internal ar in the ACGME Glossary of Terms) mu
VI.F.5.b) VI.F.5.c)	maximum weekly limit. (Core) PGY-1 residents are not permitted to moonlight. (Core)	6.25.b.	maximum weekly limit. (Core) PGY-1 residents are not permitted to
	In-House Night Float		
VI.F.6.	Night float must occur within the context of the 80-hour and one-day-off-in- seven requirements. (Core)	6.26.	In-House Night Float Night float must occur within the con seven requirements. (Core)

ent Language tion Period Length ods for residents must not exceed 24 nical assignments. (Core)

may be used for activities related to fective transitions of care, and/or ent care responsibilities must not be ime. (Core)

r Exceptions g off all other responsibilities, a y elect to remain or return to the stances: to continue to provide care to ient; to give humanistic attention to the

y; or to attend unique educational

Exceptions

g off all other responsibilities, a y elect to remain or return to the stances: to continue to provide care to ient; to give humanistic attention to the ly; or to attend unique educational

ducation must be counted toward the

ation-specific exceptions for up to 10 I and educational work hours to und educational rationale.

will not consider requests for exceptions week.

h the ability of the resident to achieve cational program, and must not for work nor compromise patient

h the ability of the resident to achieve cational program, and must not for work nor compromise patient

and external moonlighting (as defined nust be counted toward the 80-hour

o moonlight. (Core)

ontext of the 80-hour and one-day-off-in-

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
VI.F.6.a)	Night experiences should be of educational value. (Core)	6.26.a.	Night experiences should be of education
VI.F.6.a).(1)	Night assignments should have formal goals, objectives, and a specific evaluation component. (Detail)	6.26.a.1.	Night assignments should have formal gevaluation component. (Detail)
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 Frequence Residents must be scheduled for in-h every third night (when averaged over
VI.F.8.	At-Home Call	6.28.	At-Home Call Time spent on patient care activities count toward the 80-hour maximum v home call is not subject to the every- the requirement for one day in seven when averaged over four weeks. (Con
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 activities count toward the 80-hour maximum v home call is not subject to the every- the requirement for one day in seven when averaged over four weeks. (Con
VI.F.8.a).(1)	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)	6.28.a.	At-home call must not be so frequent reasonable personal time for each rea

tional value. (Core)

l goals, objectives, and a specific

#### ncy

n-house call no more frequently than ver a four-week period). (Core)

es by residents on at-home call must n weekly limit. The frequency of atry-third-night limitation, but must satisfy en free of clinical work and education, core)

es by residents on at-home call must n weekly limit. The frequency of atry-third-night limitation, but must satisfy en free of clinical work and education, core)

ent or taxing as to preclude rest or resident. (Core)