



Graduate Medical Education Policy *2003*

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Graduate Medical Education Policy

Table of Contents

1. Policy	3
2. Philosophy	3
3. Reviews	4
4. Institutional Commitment	4
5. Program Organization and Responsibilities	12
6. Eligibility and Selection of Residents	13
7. Types of Programs	13
8. Relationship Between Medical Center, Residency Programs and Residents	14
9. Statement of Review and Approval	16
Appendix A, Reference List	17
Appendix B1 Professional Education Committee	19
Appendix B2, Residency Advocacy Team	21
Appendix B3, Institutional Coordination Committee	23
Appendix B2, House Officers Council	25
Appendix C, Evaluation Policy/Procedures – Resident Staff	27
Appendix D, Due Process/Discipline/Probation/Dismissal	29
Appendix E, Annual Program Update	30
Appendix F, Mid-Cycle Review of Residency Programs	31
Appendix G, Resident Agreements	37
Appendix H, Responsibilities and Benefits	59

Graduate Medical Education Policy

1. Policy. The AFMS sponsors and supports graduate medical education through the policies and procedures established in AFI 41-117, *Medical Service Officer Education*. This instruction, together with other applicable Air Force instructions and guidance (Appendix A), is the basis for administration, management and evaluation of all graduate medical education (GME) programs, to include dental and medical residency programs. The policy and procedures set forth in AFI 41-117, together with *The Essentials of Accredited Residencies in Graduate Medical Education*, and the Council on Dental Education of the American Dental Association (ADA) guidelines, are the benchmarks for the development, conduct, and evaluation of GME programs at this medical center.

The Director of Medical Education (DME) and individual residency program directors have direct access to the Medical Group Commander, Chief of the Medical Staff and Administrator and the Squadron Commanders, as appropriate, on matters relating to facility needs and resources for GME programs. Each GME program is assigned to a Squadron and Flight for military command and control purposes. It is the policy of the Commander, 60th Medical Group, that all sponsored GME programs will be fully supported by the resources of the medical center to assure:

1.1 The delivery of quality graduate medical education for each enrolled graduate medical education student.

1.2 Sponsored programs meet the accreditation standards established by the Accreditation Council for Graduate Medical Education (ACGME) and the Council on Dental Education of the ADA.

1.3 All pertinent Air Force directives relating to the conduct of graduate medical education are duly implemented. (See Appendix A for Reference List).

1.4 The education mission of the medical center will not be compromised by excessive reliance upon residents to fulfill medical center service requirements, except in times of national emergency.

1.5 The quality of medical care for our patients will not be compromised.

2. Philosophy. The medical center sponsors GME programs as part of its assigned mission (AFI 41-117). Successful accomplishment of that mission requires the conduct of GME programs to provide quality education for residents training to become specialists in their respective disciplines (Family Practice, General Surgery, Internal Medicine, Obstetrics-Gynecology, Pediatrics, Pharmacy, Diagnostic Radiology, Oral and Maxillofacial Surgery and Advanced Education in General Dentistry) and for Transitional Year residents who seek a broad clinical base for immediate practice or future graduate medical education.

2.1 These educational programs allow the medical center to satisfy the needs of the AFMS for fully qualified practitioners in support of the assigned missions and goals in the delivery of quality health care to active duty military personnel, retired military personnel, and other eligible beneficiaries, in executing the peacetime and wartime missions.

2.2 The conduct of accredited, quality GME programs enhances both the medical and dental professions and benefits society at large by producing highly qualified practitioners ready to assume their roles as physicians and dentists and potential teachers of future physicians and dentists.

2.3 The single most important responsibility of any program of GME is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident's professional and personal development while ensuring safe and appropriate care for patients.

3. Reviews. The policy, philosophy, and procedures embodied in this policy will be reviewed and affirmed annually by the Professional Education Committee (PEC) and bi-annually by the Executive Committee as evidence of continued commitment and support of all sponsored GME programs conducted at this USAF medical center.

4. Institutional Commitment. Institutional commitment to, and responsibility for, graduate medical education, as required by *Part I - General Requirements of the Essentials* (ACGME) and the Council on Dental Education of the ADA, are met as follows:

4.1 Reasons for Institutional Sponsorship of GME Programs. The policy and philosophy stated in paragraphs 1 and 2 above, establish the reasons why the 60th Medical Group sponsors GME programs. The review required by paragraph 3 will attest to the continued commitment and support of the commander, other executive managers and the teaching/attending staff for the conduct of quality graduate medical education at this medical center.

4.2 Accreditation. The medical center maintains accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as further evidence of its commitment to quality patient care and graduate medical education.

4.3 Institutional Resources for Educational Purposes.

4.3.1 Resources, including personnel, funds and facilities, for the operation of the medical center, are provided by manpower standards, budget guidance and other directives through U.S. Air Force command channels including: the Surgeon General, USAF, Washington, D.C. (HQ USAF/SG); Headquarters, Air Force Personnel Center (HQ AFPC/DPAM), Randolph AFB, Texas; and the Office of the Surgeon, Headquarters, Air Mobility Command, Scott AFB, Illinois (HQ AMC/SG). The special needs of Air Force teaching centers are provided for in manpower authorizations, staffing policies and in the allocation of medical center operation and maintenance budgets. Every effort is made to assure that personnel and funding needs of teaching centers are given appropriate priority consideration in the allocation of these resources.

4.3.2 At the medical center level resources are allocated as follows:

4.3.2.1 The DME is the central point of contact for the funds to meet the education and training needs of GME programs. Each teaching flight is authorized personnel and special additives are included in the Air Force manpower standards to provide teaching staff.

4.3.2.2 The DME is appointed by the Medical Group Commander (AFI 41-117) to function as the focal point for all graduate medical education activities in the medical center. The DME provides for overall management administration, evaluation of graduate medical education activities and supports the PEC, Residency Advocacy Team (RAT) and individual program directors in the execution of their responsibilities. The DME centralizes the individual budgets for graduate medical education needs, including medical and dental textbooks, journals, instructional aids and devices. The DME is responsible for audiovisual software and hardware, medical photography and illustration, manages the system for requesting and allocating quotas for training courses for the staff and supports continuing medical and dental education for the staff. A full-time director and DME support personnel, including two GME program coordinators, a librarian, a library technician, two medical photographers and two medical illustrators, staff the function.

4.3.2.3 See Appendix A for a list of key medical center personnel and their organizational positions.

4.4 Guidelines for the selection, evaluation, promotion and dismissal of residents and staff.

4.4.1 Appointment of Teaching Staff. The Commander, 60th Medical Group, in conjunction with HQ AMC/SG, and HQ AFPC/DPAM, assures that teaching departments are adequately staffed with qualified physicians and dentists capable of assuming a teaching role in the sponsored GME programs. Personnel selected for assignment to teaching centers are selected on the basis of their qualifications as teachers in their respective specialty areas, board certification/eligibility, experience and interest in teaching. The flight commander, squadron commander, chief of the medical staff (for medical corps) and group commander carefully assess the teaching role and capability of the medical and dental staff during required periodic evaluations (Officer Evaluation System). While the selection and assignment of teaching staff are managed through the established Air Force personnel system, program directors (medical corps) play an active and direct role in the selection process through coordination with the commander (squadron and/or group) and the clinical consultants to the HQ USAF/SG.

4.4.2 Appointment of Residents. Appointment of medical residents to GME programs is accomplished through the Department of Defense (DOD) Joint Services Graduate Medical Education (JSGME) Selection Board convened each year. The JSGME Selection Board is divided into panels for each residency/fellowship program sponsored by the Air Force, Army and Navy Medical Services. The number of positions filled in Air Force teaching programs is based upon the number of residency/fellowship positions approved for each program throughout the Air Force, and authorized via the annual Integrated Forecast Board (IFB). Depending upon the needs of the DOD, applicants may be appointed to other Federal graduate medical education programs or selected for either sponsored or deferred status in civilian GME programs. Each candidate for a GME position submits an application and other documentation to

the JSGME Selection Board. AF selections made by the panels are reviewed and approved by the board president and the HQ USAF/SG. An AF Dental Corps selection board at HQ AFPC/DPAM accomplishes appointment of dental residents.

4.4.3 Supervision Policy. Residents must be supervised by teaching staff in such a way that the trainees assume progressively increasing responsibility for patient care according to their level of training, ability, and experience. On-call schedules for teaching staff must be structured to assure that supervision is readily available to the resident on duty. The teaching staff must determine the level of responsibility afforded each resident. The attending/teaching staff and senior residents supervise residents while on a clinical rotation, and residents will not be assigned duties where such supervision is not available. The appointed supervising staff physician is responsible for the care of the patient and for the conduct and performance of the resident physician. In addition, the DME, the appropriate program director, teaching staff, flight commanders, department chairpersons, chiefs of services as well as the Chief of the Medical Staff (medical corps) monitor the progress and performance of each resident. The RAT and PEC monitor the overall progress and performance of residents. When residents perform off-site clinical rotations for specific educational experiences, arrangements are made by the program director for appropriate evaluation/supervision by the person responsible for the resident at the site.

4.4.4 Written Evaluation. A written resident evaluation is accomplished monthly, or at the end of each clinical rotation by the attending physician, dentist, or pharmacist responsible for the resident's education and performance on that service (see Appendix C). An annual training report (AF Form 475) is prepared for each resident by the appropriate program director as required by AFI 36-2406. A final written evaluation is prepared for each resident upon completion of the residency program. Residents identified as deficient or in need of specific assistance are counseled by the program director (or designee), the DME and the attending physician or dentist. Specific assistance, including tutorials, is made available according to the needs of the resident and the assessment of the faculty. Residents identified for possible probation or dismissal are identified to the RAT/PEC.

4.4.5 Advancement of Residents. Procedures for advancement of residents are established by each program director in consonance with the applicable section of *Part 2 - Special Requirements of the Essentials of the ACGME* and the ADA.

4.4.6 Procedures for Discipline/Probation/Dismissal of Residents. Procedures for discipline, probation and dismissal are established in AFI 41-117, Chapter 2; or if unrelated to medical practice, in the *Uniform Code of Military Justice (UCMJ)*. All potentially adverse actions affecting a graduate medical education student are referred to the PEC and/or the RAT as required by AFI 41-117. The final authority on disciplinary actions rests with the Squadron Commander. This procedure is briefly outlined in Appendix D.

4.4.7 Due Process for Resident Staff (Appendix D). Due process for resident staff is guaranteed by the *UCMJ, Boards of Officers* (AFI 51-602), *Medical Service Officer Education* (AFI 41-117), and other instructions listed in Appendix A concerning discipline, promotion, evaluation or elimination from residency programs or separation from the Air Force. These instructions describe in detail the steps necessary for such actions and guarantee the right to be heard for resident staff.

4.4.7.1 For resident staff, hospital-level due process begins with referral to the RAT and/or PEC. In addition to these protections for due process, resident staff can freely be heard through established Air Force programs such as the *Air Force Inspector General System* (AFI 90-301). Residents are provided with an explanation of these rights and procedures of due process during the Resident Orientation conducted prior to the start of the academic year for each new resident staff.

4.4.7.2 There are specific procedures for restriction, suspension, termination, or withdrawal from a residency program. AFI 41-117 ensures due process is achieved. The PEC may or may not be involved in the early stages; however, the committee and/or DME is made aware of the case and reviews the case prior to the resident being placed on probation. The resident must be informed in writing and given three duty days to respond, if desired. The probation notification letter will outline specific tasks for the resident to complete. If not completed to satisfaction, suspension, termination, or withdrawal from the program may be warranted. Should this situation occur, the resident may request a faculty board to review the case. The resident may be represented by a lawyer (at personal expense), call witnesses and present documents. The faculty board, appointed by the Medical Group Commander and consisting of the Chief of the Medical Staff or designee and two to four qualified officers (total of three to five), will call persons to testify, review documents and make a recommendation through the DME to the Medical Group Commander. If the Medical Group Commander recommends to HQ AFPC/DPAM a delay in completion or termination of the resident's program, the resident has ten days to submit a written appeal to HQ AFPC/DPAM. The decision of HQ AFPC/DPAM is final.

4.4.8 Research. Residents are highly encouraged to participate in research while in their residency programs. Support from the Clinical Investigation Facility (CIF) is available and the residents are briefed on resources available during resident orientation. Air Force clinical societies and DGMC sponsor various research awards.

4.4.9 Residency Closure/Reduction. In the event of a reduction or closure of a program, the residents will be allowed to complete their education or will be assisted in enrolling in an ACGME accredited program in which they can continue their education.

4.5 Annual Update of Programs (Appendix E). In addition to required reviews conducted by accrediting bodies (residency review committees), health services inspections (HSI) conducted by the Directorate of Medical Inspection, Air Force

Inspection Agency, and staff assistance visits (SAV) from HQ AMC/SG, each GME program will be evaluated annually by the RAT.

4.5.1 The annual update will include:

4.5.1.1 The results of all in-service or other examinations used to evaluate student progress

4.5.1.2 Report the board examination results for all program graduates

4.5.1.3 Report compliance with ACGME work hour policy

4.5.1.4 Address previous RRC citations and concerns, potential problem areas in next review

4.5.1.5 DME will consolidate input and report to the PEC

4.5.2 The House Officers Council (HOC) will annually survey the residents from each residency program and report their findings to the PEC.

4.6 Mid-Cycle Review of Residency Programs (Appendix F).

4.6.1 In addition to the annual review, a mid-cycle review of the residency programs will be conducted at the mid-point between scheduled ACGME and ADA program surveys. The DME will appoint a mid-cycle review committee, composed of a program director, senior resident and administrator. The committee will assess:

4.6.1.1 The program's compliance with the specialty standards;

4.6.1.2 The educational objectives of each program;

4.6.1.3 The adequacy of available educational and financial resources to meet these objectives;

4.6.1.4 The effectiveness of each program in meeting its objectives; and

4.6.1.5 The effectiveness in addressing citations from previous ACGME/ADA letters of accreditation and previous internal reviews.

4.6.2 The mid-cycle review will assess whether the program has defined, in accordance with the relevant Program Requirements, the specific knowledge, skills, and attitudes required and provides educational experiences for the residents to demonstrate competency in the following areas: patient care skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

4.6.2.1 The mid-cycle review will ensure that the program provides evidence of the program's use of evaluation tools to ensure that the residents demonstrate competence in each of the six areas.

4.6.2.2 The mid-cycle review will appraise the development and use of dependable outcome measures by the program for each of the general competencies.

4.6.2.3 The mid-cycle review will appraise the effectiveness of each program in implementing a process that links educational outcomes with program improvement.

4.6.3 Materials and data to be used in the review process should include the following:

4.6.3.1 Institutional and program requirements from *The Essentials of Accredited Residency Programs* and the ADA;

4.6.3.2 Letters of accreditation from previous ACGME/ADA reviews;

4.6.3.3 Reports from previous annual reviews/updates of the program; and

4.6.3.4 Interviews with the program director, faculty and residents in the program and individuals outside the program deemed appropriate by the committee.

4.6.4 A report of the review will be provided to and briefed at the quarterly PEC. In addition, succinct summaries of each review will be provided by the PEC to the Executive Committee. The final report is forwarded by the DME to the Medical Group Commander.

4.7 Interinstitutional Agreements. Formal training affiliation agreements (TAA) exist between 60th Medical Group (DGMC) and the following institutions to provide additional opportunities for clinical training of graduate medical education residents:

4.7.1 Brooke Army Medical Center, San Antonio, Texas. Burn management training of general surgery residents.

4.7.2 Oakland Children's Hospital, Oakland, California (CHO). Pediatric intensive care unit training for pediatric residents, pediatric radiology training for diagnostic radiology residents, and pediatric surgery for general surgery residents.

4.7.3 University of California, Davis, School of Medicine (UCD). Provides for an exchange of residents, medical students and staff between DGMC and UCD. UCD supports clinical training in medical intensive care unit, trauma, transplant, ER, surgical, diagnostic radiology, pediatric ward, neonatal intensive care unit rotations and other subspecialty rotations as required.

4.7.4 Department of Veterans Affairs Northern California Health Care System. This affiliation agreement allows medical students and residents from the VA to rotate at DGMC as well as our residents to rotate at their various facilities in the Northern California region. Primarily used by family practice and internal medicine residency programs.

4.7.5 Kaiser Permanente Medical Group, Northern California. Provides residency training primarily for internal medicine, OB/Gyn and general surgery residents.

4.7.6 Veterans' Home of California, Yountville, California. Family practice and internal medicine residents rotate for training in geriatric medicine.

4.7.7 University Medical Center, Fresno, California. Oral and maxillofacial surgery (OMS) residents expand their experience in head and neck trauma on the OMS service. Each resident also functions as an emergency room physician for one month under the supervision of ER attending staff, and as a member of the general surgery trauma team for one month.

4.7.8 University of California, San Francisco, California. Primarily high-risk obstetrics rotation for OB/Gyn residents.

4.7.9 Santa Clara Valley Medical Center, San Jose, California. OB/Gyn rotation for family practice residents.

4.8 Formal TAAs are developed and processed for approval as required by AFI 41-108, *Training Affiliation Agreement Program*. A new TAA may be initiated if it fills a bona-fide shortfall in training capacity, cannot be satisfied by an existing TAA and is with an accredited institution recognized by the U.S. Air Force Medical Service. Requests to initiate a TAA should be received by the DME at least six months in advance of the planned rotation.

4.9 In addition to the formal TAAs with the various institutions that are broad in scope and content, each program director must ensure that a letter of agreement exists between the program directors at each institution; these agreements should:

4.9.1 Identify the officials at the participating institution or facility who will assume administrative, educational, and supervisory responsibility for the resident(s);

4.9.2 Outline the educational goals and objectives to be attained within the participating institutions;

4.9.3 Specify the period of assignment of the residents to the participating institution, the financial arrangements and the details for insurance and benefits;

4.9.4 Determine the participating institution's responsibilities for teaching, supervision and formal evaluation of the residents' performances; and

4.9.5 Establish with the participating institution the policies and procedures that govern the resident's education while rotating to the participating institution.

4.10 Off-Site Rotation Support. Off-site rotations will be sponsored in accordance with finance guidelines and institution budgetary constraints. Elective rotations to military healthcare facilities generally will be in permissive TDY (unfunded) status. Funded elective rotations to civilian institutions may be approved if funds are available and are limited to one per graduating resident; the civilian institution must provide approved professional malpractice insurance. All TDY elective rotations must be approved by the program director and DME. Generally the cost of a funded TDY elective rotation should not exceed \$3000 (transportation, lodging, meals and incidental expenses). Rental cars are generally not approved; an exception would be if the rental car were required to take advantage of no-cost or low-cost lodging.

4.10.1 Commuting. Rotations in the local area do not require a written travel order. Vicinity travel, to the extent that the commuting distance exceeds the member's normal commute to the permanent duty station (PDS), may be approved. The individual residency program directors and DME will determine which rotations fall within these guidelines.

4.10.2 Northern California TDY Rotations: This policy applies to all required rotations in Sacramento, Santa Clara, Fresno and the East Bay area which have prolonged work hours, in excess of 12 hours and/or require overnight lodging. In most cases, this is limited to those rotations with in-house call. The purpose is to promote safety for fatigued residents by limiting driving distance, and to

standardize funding of away rotations. The individual residency program directors and DME will determine which rotations fall within these guidelines.

4.10.2.1 Contract billeting has been acquired in Santa Clara, East Bay, Fresno and Sacramento within easy driving distance of required rotation sites.

4.10.2.2 Any resident on an applicable rotation will be placed on TDY orders and is expected to stay at the contract billeting to reduce driving time and the risk of driving while fatigued.

4.10.2.3 The DME support staff will coordinate use of the contract billeting. Residency program directors will provide the designated contract billeting coordinator with a list of residents and dates needed. If the number of residents exceeds the space available, priority will be given to residents with overnight call. Residents who cannot be provided a room in the contract billeting will be provided an appropriate alternative.

4.10.2.4 The requirement for complete privacy/security was recognized when the contract billeting was obtained. Two separate bathrooms and two separate bedrooms are available in each contract-billeting site. This provides complete privacy and separation. Professional conduct is expected. Any problems are to be reported immediately to the DME and applicable residency program directors.

4.10.2.5 TDY funding for these rotations will be limited to one round-trip from home to the off-site locale, unless additional round-trips have been approved in advance by the DME. Meals are available at UCD, Santa Clara, Children's Hospital Oakland and University Medical Center at no cost for most residents. Local travel in and around the off-site locale is not approved.

4.10.3 Other TDY Rotations. Required rotations at sites outside of the local area will require TDY orders. Program Directors shall require use of military billeting when possible.

4.10.4 Reimbursement. All TDY requests (MDGI Form 4) and vouchers for reimbursement for TDY (DD Form 1351-2) or Vicinity Travel (SF Form 1164) must be approved by the residency program director and DME. All vouchers will be sent to RMO for review and forwarded to the AFO for processing and reimbursement. A copy of the final payment voucher (Travel Summary) must be provided to RMO within five days of receipt.

4.11 Facilities and Resources. In addition to the facilities available in the various teaching areas and clinical departments, the following facilities and services are available in support of graduate medical education programs:

4.11.1 Medical Library. The collection encompasses approximately 24,500 bound volumes, including journals, standard texts and references in the various medical specialties, and an additional 435 periodical subscriptions encompassing the various medical and dental specialties. Internet access is also available. In addition to the main library facility, departmental specialty reference libraries are maintained. Residents are provided full access to the library, services include interlibrary loans, electronic bibliographic and literature search capability. A photocopier is available for residents' use at no charge. Photocopy services, within the boundaries of the Copyright Law, will be provided.

4.11.2 Medical Multimedia Center. The services of two full-time medical photographers and two full-time medical illustrators are available to the staff and residents for medical documentation and medical teaching materials.

Videoteleconferencing facilities are also available.

4.11.3 Clinical Investigation Facility. Laboratory, vivarium, statistical and administrative support is provided for human and animal research projects. In addition, a number of surgical and pediatric training laboratories are available for resident and staff training. Resident participation in clinical investigation projects is encouraged and actively supported. In addition, each year one general surgery resident dedicates an entire year to clinical research.

4.11.4 Resident Resources. Classroom/conference/study areas are available in the residency program flights, as well as in the medical library. In addition, a wide range of audiovisual hardware and software is available to the staff and residents for teaching/ learning purposes.

4.11.5 Work Environment:

4.11.5.1 Food service is available in the DGMC dining room and frozen meals, box lunches or hot plates are available for after-hours meals. In addition, fresh food is available in a small vending area and local restaurants deliver. Dedicated call rooms have been established for all residency programs requiring in-house call.

4.11.5.2 Patient support services, such as intravenous services, phlebotomy services and laboratory services, as well as messenger and transport services will be provided in a manner appropriate to and consistent with educational objectives and patient care.

4.11.5.3 A complete medical records department is maintained in accordance with AFI 41-117 and AFI 41-210, *Patient Administration Functions*.

4.11.5.4 Clinical support services, including pathology and radiology, are available. The College of American Pathologists has accredited the Department of Pathology.

4.12 Hospital Accreditation. The Joint Commission on Accreditation of Healthcare Organizations accredits the medical center as required by AFI 41-117.

5. Program Organization And Responsibilities

5.1 Qualification of Program Staff. The program staff and program director are selected from board certified/board eligible candidates from the specialty involved. Selection of an individual to serve as a program director is made in coordination between the medical group commander, the squadron commander and appropriate representatives of HQ USAF/SG and HQ AFPC/DPAM. The program director participates in the selection of program staff in coordination with the squadron and/or group commander.

5.2 Authority of Program Director. Each program director is given full authority to administer his/her program in accordance with all established criteria set forth in Air Force instructions, this policy and the *requirements of the accreditation*

organization (eg, ACGME, ADA). Sufficient time for administration of the duties will be made available by the Commander and Chief of the Medical Staff and Squadron Commander according to the needs of the program and the needs of the medical center.

5.3 Teaching Staff. All members of the staff are encouraged to actively support and participate in the teaching programs of the medical center. Key professional personnel, including teachers, clinicians, and administrators will:

5.3.1 Have adequate special training and experience in their specialty areas.

5.3.2 Actively participate in appropriate national and regional scientific societies.

5.3.3 Participate in their own continuing medical education as required by their specialty, licensure agencies and AFI 41-117.

5.3.4 Engage in specific presentations as appropriate.

5.3.5 Exhibit active interest in medical research related to their specialties.

5.3.6 Supervise residents in such a way that the trainees assume progressively increasing responsibility for patient care according to their level of training, ability, and experience. On-call schedules for teaching staff must be structured to assure that supervision is readily available to the resident on duty. The teaching staff must determine the level of responsibility afforded each resident. The components of supervision include:

5.3.6.1 The supervisor's assessment of the skill level of the trainee.

5.3.6.2 The supervisor's comfort level with authorizing independent action.

5.3.6.3 Progressive independence in performing functions together with decreasing frequency of spot-checking. Supervision starts with close supervision; progressively encourages independence as skills are observed.

5.3.6.4 Written evaluation and feedback are considered in the progression levels. At all times, the resident has access to advice and direction from the supervisor.

5.4 Relationship between Medical Staff and GME Programs. At this medical center, no distinction is made between the teaching staff and non-teaching staff of a medical department. Each member of the professional staff is expected to support the GME programs and participate actively in the teaching and supervision of residents. There is a distinction made within the dental residencies; teaching staff is separately identified for dental programs.

6. Eligibility and Selection of Residents. Eligibility for enrollment in Air Force GME programs is established by Air Force policy. Primarily candidates must be accepted for Air Force commission and be on active duty at the time their GME program begins. Determination of acceptability for an Air Force commission and active duty is specified in appropriate Air Force personnel instructions.

7. Types of Programs. The graduate medical education programs currently offered at this medical center are:

7.1 A three-year Family Practice Residency accredited by the ACGME.

7.2 A one-year Transitional Year Residency accredited by the ACGME.

- 7.3 A three-year Pediatric Residency accredited by the ACGME.
- 7.4 A five-year General Surgery Residency accredited by the ACGME. In addition, there are one-year preliminary year residents.
- 7.5 A one-year Clinical Research Residency accredited with the General Surgery Residency by the ACGME.
- 7.6 A four-year Obstetrics and Gynecology Residency accredited by the ACGME.
- 7.7 A four-year Diagnostic Radiology Residency accredited by the ACGME.
- 7.8 A three-year Internal Medicine Residency accredited by the ACGME.
- 7.9 A four-year Oral and Maxillofacial Surgery Residency accredited by the ADA Commission on Dental Accreditation.
- 7.10 A one-year Advanced Education in General Dentistry Residency accredited by the ADA Commission on Dental Accreditation.
8. Relationship between Medical Center, Residency Programs and Residents.
- 8.1 Teaching and Learning. Residents will be included in all medical and dental staff programs of medical education and will attend all department/service meetings, teaching rounds and conferences while on a particular service. Residents will be assigned progressive responsibility for patient care by teaching/attending staff in consonance with the established curriculum for each service. The teaching/attending staff will assure that each resident has an opportunity to develop teaching skills by teaching the more junior residents, medical students and other medical center personnel. Each department/service will establish and conduct organized formal teaching sessions tailored to meet the needs of the programs as required by the curriculum, AFI 41-117, guidance from the PEC, and the special requirements of ACGME for approved residencies.
- 8.2 Resident Staff Participation in Committees, Policy Development and Review. Residents will be encouraged to participate in relevant committees, to include the PEC and the Executive Committee of the Medical Staff (ECOMS) while in their residency programs. Chief and/or senior residents will be assigned as voting members to hospital-wide committees as part of their educational experience. Residents will be encouraged to participate in policy development and review at periodic HOC Meetings and through attendance at service meetings.
- 8.3 Supervision of Resident Staff. There must be sufficient institutional oversight to assure that resident staff is appropriately supervised. An assigned attending staff member will supervise each resident. Senior residents will be given specific responsibilities for supervision of junior residents and medical students. Residents will be given responsibilities for patient care commensurate with their levels of training and demonstrated performance. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to resident on duty. Resident staff will not be assigned duties where supervision by a senior resident or attending physician or dentist is not available.

8.4 Duty Hours: Each residency program establishes formal policies governing resident duty hours that foster resident staff education and facilitate the care of patients. Duty hours must meet the requirements of the ACGME with respect to total hours, on-call limitations, and days off.

8.4.1 The educational goals of the program and learning objectives of the resident staff must not be compromised by excessive reliance on residents to fulfill service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided appropriate backup support when patient care responsibilities are especially difficult or prolonged.

8.4.2 Resident staff duty hours and on-call time periods must not be excessive. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hours must be consistent with the Institutional and Program Requirements that apply to each program.

8.4.3 Each program shall endeavor to avoid assigning resident staff to continuous hours that extend over an unreasonable period of time. In-house call, on average, should be no more than every third night. Each program shall try to fairly schedule duty times for each resident, including the provision of adequate off-duty hours. Resident staff, whenever possible, will not have intense demanding rotations scheduled back-to-back during the academic year. Each program will arrange coverage so residents can average one 24-hour break from patient care over each seven-day period during a four-week rotation.

8.5 Compensation. Compensation for resident staff is determined by Public Law and detailed in appropriate Air Force instructions. Each resident shall be provided a detailed record of pay at the end of each established pay period.

8.6 Counseling and Physician Impairment. Frequent periodic counseling will be provided for resident staff by the teaching/attending staff, program directors and/or the DME to assist residents with adjustments to the demand and stresses of the residency. Counseling and psychological support through mental health professionals will be made available to resident staff as needed. It is the duty of officers to report suspected drug abuse. Impairment of any kind should be reported to the resident's program director who will take appropriate action. The USAF has extensive services available for the treatment of physical and mental impairment, including substance abuse. Physical or mental impairment that is inconsistent with continued active duty may result in termination of participation in the residency program and separation or retirement in accordance with AF instructions. Substance abuse is inconsistent with continued military service.

8.7 Evaluation and Advancement. The resident staff will be evaluated as described in paragraphs 4.4.4 and 4.4.5 and Appendix C of this policy.

8.8 Due Process. Due process protections are as described in paragraph 4.4.7 and Appendix D of this policy.

8.9 Resident Staff Responsibilities. The resident staff are expected to:

8.9.1 Develop a personal program of learning to foster continued professional growth with guidance from the teaching staff;

8.9.2 Participate in safe, effective and compassionate patient care, under supervision, commensurate with their level of advancement and responsibility;

8.9.3 Participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervision of other residents and medical students;

8.9.4 Participate as appropriate in institutional programs and medical staff activities and adhere to established practices, procedures and policies of the institution.

8.9.5 Participate through peer-nominated representation on institutional committees and councils whose actions affect their education and/or patient care; and

8.9.6 Submit at least annually confidential written evaluations of the faculty and of the educational experiences to the program director.

8.9.7 Each medical resident shall complete the United States Medical Licensing Examination (USMLE) Step 3, or Comprehensive Osteopathic Medical Licensure Examination (COMLEX), as appropriate, at the earliest opportunity but not later than 15 March, during the PG-1 year. An unrestricted state medical license shall be obtained not later than the end of the PG-2 year. Residents who only receive one year of initial training must apply for an unrestricted state license as soon as possible during their PG-1 year. Residents who entered the residency programs with a valid state license must retain an unrestricted state medical license while in their residency programs. Medical, Dental and Nurse resident staff will maintain their professional licenses during their residency training.

8.9.8 Adhere to the dress and appearance standards in accordance with AFI 36-2903, MDGI 36-11 and Medical Center Policy.

8.10 Resident Staff Agreement. Upon entering the program at this medical center, each graduate medical education resident will be provided a copy of the Resident Staff Agreement that summarizes residency requirements, curriculum, assignment policy and other information for the resident. A signed copy of this agreement will be filed in the resident's training record.

9. Statement of Review and Approval. This policy has been reviewed by the PEC, the program directors, the DME, the Chief of the Medical Staff, the Commander and has been approved by the Executive Committee of the 60th Medical Group.

Appendix A - Reference List

AFCAT 36-2223	USAF Formal Schools
AFI 36-2107	Active Duty Service Commitments and Specified Period of
Time Contracts	
AFI 36-2301	Professional Military Education
AFI 36-2406	Officer and Enlisted Evaluation Systems
AFI 36-2706	Military Equal Opportunity and Treatment Program
AFI 36-2903	Dress and Personal Appearance of Air Force Personnel
AFI 36-2909	Professional and Unprofessional Relationships
AFI 36-3003	Military Leave Program
AFI 36-3006	Survivor Benefit Plan
AFI 36-3008	Servicemen's Group Life Insurance (SGLI)
AFI 40-501	The Air Force Fitness Program
AFI 40-502	The Weight and Body Fat Management Program
AFI 41-104	Professional Board and National Certification
AFI 41-108	Training Affiliation Agreement Program
AFI 41-109	Special Pay for Health Professionals
AFI 41-117	Medical Service Officer Education
AFI 41-210	Patient Administration Functions
AFI 44-119	Medical Service Clinical Quality Management
AFI 47-101	Managing Air Force Dental Services
AFI 48-123	Medical Examination and Standards
AFI 90-301	Inspector General Complaint System
AFMAN 10-100	Airman's Manual
AFPAM 36-2705	Discrimination and Sexual Harassment
AFVA 40-503	United States Air Force Maximum Allowable Weight (MAW)
Table	
10 United States	Disability Retirement and Separation
Code Chap 61	
28 United States	Westfall Act
Code Sec. 2679	
38 United States	VA disability compensations for service-connected defects
Code	
GME Reference	Orientation Briefings, Publications (AFIs, MDGIs, Policies),
Compact Disk	Forms, Reference Sites, Software
ACGME	The Essentials of Accredited Residencies in Graduate
	Medical Education
ADA	American Dental Association - Requirements for Advanced
	Specialty Education Programs
JCAHO	Joint Commission on Accreditation of Healthcare
	Organizations - Accreditation Manual for Hospitals

Key Personnel

Title	Rank	Name
Commander	Col	James D. Collier
Vice Commander	Col	Fred M. Hannan, Jr.
Administrator	Lt Col	Randall Emmert
Director, Medical Education	Lt Col	Barbara B. Erickson
Director, Military Medical Education	Lt Col	Norma Allgood
Chief of the Medical Staff	Col	Gregory P. Melcher
Chief Nurse Executive	Col	Thomas J. Tegeler
Biomedical Advisor	Col	Harvey Adams
Dental Advisor	Col	George J. Gerdtz
Medical Law Consultant	Maj	Wendy Sherman
Commander, Medical Operations SQ	Col	Barry L. Simon
Commander, Aerospace Medicine SQ	Col	Victor P. Salamanca
Commander, Dental SQ	Col	George J. Gerdtz
Commander, Medical Support SQ	Col (sel)	Mark L. Allen
Commander, Diagnostics & Therapeutics SQ	Col	Harvey Adams
Commander, Surgical Operations SQ	Lt Col	Dianne Harris
Program Director, Family Practice	Lt Col	Jefferson H. Harman, Jr.
Program Director, Internal Medicine	Col	Kathryn M. Amacher
Program Director, Transitional Year	Lt Col	Eric B. Stone
Program Director, Pediatrics	Lt Col	Mary M. Pelszynski
Program Director, Diagnostic Radiology	Col	Raymond S. Dougherty
Program Director, General Surgery	Maj	Jon Perlstein
Program Director, Obstetrics and Gynecology	Lt Col	Andrew C. Steele
Program Director, Advanced Education in General Dentistry	Lt Col	Jeffery Denton
Program Director, Oral and Maxillofacial Surgery	Lt Col	Ronald Berry
Program Director, Pharmacy Practice	Dr.	Sian Carr-Lopez
Program Director, Certified Nurse Anesthesia	Lt Col	Sylvia Cayetano
Program Director, Social Work	Maj	Sara Ramirez

Appendix B1 - Professional Education Committee (PEC)

1. Purpose. The Professional Education Committee (PEC) is the advisory body to the Director of Medical Education (DME). Its purpose is to plan, develop, monitor and advocate all in-house health education programs as identified by USAF policy or instruction, or by the Medical Group Commander.

2. Membership:

Director, Medical Education (Chair)

Director, Military Medical Education

Assistant Director, Medical Education

Residency Program Director, Internal Medicine

Residency Program Director, General Surgery

Residency Program Director, Obstetrics and Gynecology

Residency Program Director, Pediatrics

Residency Program Director, Family Practice

Residency Program Director, Diagnostic Radiology

Residency Program Director, Transitional Year

Residency Program Director, Advanced Education in General Dentistry

Residency Program Director, Oral and Maxillofacial Surgery

Residency Program Director, Pharmacy Practice

Residency Program Director, Physician Assistant Orthopaedic Surgery

Program Director, Social Work

Clinical Director, Nurse Anesthesia

Chief, Group Education & Training

Medical Librarian

Medical Training Programs Advisor (MTPA)

Enlisted Specialty Training Representative

House Office Council (HOC) Representative

Senior GME Program Coordinator (Recorder)

3. Meetings. Quarterly, or more frequently as necessary. Ordinarily meetings are held on the third Thursday of Mar, Jun, Sep, and Dec. When the agenda includes important matters (such as changes in operating procedures, proposed elimination or reinstatement of residents, and changes in program curricula and length), at least 60 percent of the members must be present. Absent members may be polled to ratify vote.

4. Responsibilities.

4.1 Plans and develops all in-house health educational programs as identified by HQ AFPC/SG instructions or policies, the medical group commander, or medical center committees.

4.2 Provides a forum for discussion of education activities within the facility and suggests ways to improve all education programs. Makes appropriate recommendations to Executive Committee/Medical Group Commander.

- 4.3 Guides the DME on the acquisition and use of equipment and educational facilities.
- 4.4 Supervises and integrates the medical center's education programs.
- 4.5 The committee or a subcommittee regularly reviews student progress.
 - 4.5.1 Evaluates resident staff with respect to probation and dismissal and recommends action to DME in accordance with AFI 41-117 and DGMC Graduate Medical Education Policy.
- 4.6 Annually reviews program curricula and evaluates the quality of the curricula, student quotas, facility support, specialty board results, financial support, financial impact of the program, and integration of each program with other programs and missions of the facility.
 - 4.6.1 Reviews all ACGME/ADA letters of accreditation and monitors the action plans for the correction of areas of noncompliance.
 - 4.6.2 Conducts regular mid-cycle reviews of all ACGME-accredited programs to assess their compliance with the *Institutional Requirements* and the *Program Requirements* of the ACGME Residency Review Committees.
 - 4.6.3 Assures that each residency program establishes and implements formal written criteria and processes for the selection, evaluation, promotion and dismissal of residents in compliance with the Institutional and Program Requirements.
 - 4.6.4 Monitors the programs in establishing an appropriate work environment and the duty hours of residents.
- 4.7 Reviews and approves minutes of Residency Advocacy Team, Dental Professional Education Sub-Committee, Library Advisory Committee and Education and Training Function.
- 5. DME will forward a copy of the minutes to the Chief of the Medical Staff.
- 6. Authority. *Medical Service Officer Education* (AFI 41-117); DGMC Graduate Medical Education Policy.
- 7. Accountability. Minutes will be prepared and forwarded to the medical group commander for approval and reviewed quarterly by the Executive Committee. Office of record for PEC minutes is the Directorate of Professional Education and Training (SGT).

Appendix B2 - Residency Advocacy Team (RAT)

1. Purpose. The Residency Advocacy Team (RAT) is a subcommittee of the Professional Education Committee (PEC). Its purpose is to plan, develop, monitor and advocate all graduate medical and dental education programs as identified by USAF policy or instruction, or by the Medical Group Commander.

2. Membership:

Director, Medical Education (Chair)

Director, Military Medical Education

Assistant Director, Medical Education

Residency Program Director, Internal Medicine

Residency Program Director, General Surgery

Residency Program Director, Obstetrics and Gynecology

Residency Program Director, Pediatrics

Residency Program Director, Family Practice

Residency Program Director, Diagnostic Radiology

Residency Program Director, Advanced Education in General Dentistry

Residency Program Director, Oral and Maxillofacial Surgery

Residency Program Director, Transitional Year

House Officer Council Representative

Senior GME Program Coordinator

GME Program Coordinator (Recorder)

3. Meetings. Monthly, except that once a quarter (Mar, Jun, Sep, and Dec) members of the RAT will attend the PEC in lieu of a RAT meeting. Meetings are held on the third Thursday of the month. When the agenda included important matters (such as changes in operation procedures, proposed elimination or reinstatement of residents, and changes in program curricula and length), at least 60 percent of the members must be present.

4. Responsibilities:

4.1 Plans and develops all in-house graduate medical and dental residency programs.

4.2 Provides a forum for discussion of graduate medical education activities within the facility and suggests ways to improve programs to meet ACGME/ADA and AFMS requirements. Makes appropriate recommendations to the PEC and Executive Committee/Medical Group Commander concerning graduate medical education activities.

4.3 Guides the DME on the acquisition and use of equipment and residency facilities.

4.4 Regularly review student progress.

4.4.1 Evaluates resident staff with respect to probation and dismissal and recommends actions to DME and PEC in accordance with AFI 41-117 and DGMC Graduate Medical Education Policy.

5. Annually reviews program curricula and evaluates the quality of the curricula, student quotas, facility support, specialty board results, financial support, financial impact of the program, and integration of each program with other programs and missions of the facility. Reports findings to the PEC.

Appendix B3 – Institutional Coordination Committee (ICC)

1. Purpose. The Institutional Coordination Committee (ICC) is a subcommittee of the Professional Education Committee (PEC). Its purpose is to have a major responsibility for conducting and monitoring the activities of the transitional year program.

2. Membership:

Residency Program Director, Transitional Year (Chair)
Director, Medical Education and Training (CEO designee)
Residency Program Director, Internal Medicine (Sponsor)
Residency Program Director, General Surgery (Sponsor)
Residency Program Director, Obstetrics and Gynecology (Sponsor)
Residency Program Director, Pediatrics (Sponsor)
Director, Emergency Medicine Rotation
Residency Program Director, Family Practice
Representative, Transitional Year (Transitional Intern)
Senior GME Program Coordinator (Recorder)

3. Meetings. Quarterly just prior to the Residency Advocacy Team (RAT) meeting (suggested: Feb, May, Aug, and Nov). Meetings are held on the third Thursday of the month. When the agenda includes important matters (such as changes in operating procedures, proposed elimination or reinstatement of students, and changes in program curricula and length), at least 60 percent of the members must be present.

4. Responsibilities:

4.1 To recommend to the Director, Medical Education and the Professional Education Committee (PEC) policies that establish the educational content of the transitional year and the allocation of resources for the effective conduct of the program.

4.2 To ensure that the quality of medical care provided by transitional year residents is equivalent to that expected of first-year residents in other ACGME-accredited programs within the institution.

4.3 To monitor the impact of the transitional year program on the categorical residents' programs to ensure that there is no compromise of the educational resources. This includes monitoring the adequacy of the number of patients, variety of illnesses, educational materials, teaching/attending physicians and financial support.

4.4 To review at least twice a year the evaluations of the transitional year residents' performance and the residents' assessment of the components of the transitional year, including the faculty.

4.5 To ensure that the educational opportunities provided transitional year residents are within acceptable standards of medical care and are equivalent to

those provided first-year residents in the categorical programs in which the transitional year residents participate.

4.6 To ensure that the quality of education provided by the non-accredited components of the program is reasonably comparable to that provided to the first-year residents in accredited programs.

4.7 To approve the curriculum of each transitional year resident, which has been planned with the transitional year program director in accordance with the individual needs of the residents and the Program Requirements of the Transitional Year.

4.8 To ensure that the transitional year program undergoes a periodic internal (mid-cycle) review in accordance with the general institutional requirements.

4.9 To maintain records documenting the committee's activities for each of the above requirements and to have copies of these records available for transmission the Transitional Year Review Committee.

4.10 To review ACGME letters of accreditation for program sponsors and to monitor areas of noncompliance.

5. Authority. ACGME Transitional Year Program Requirements II-C.

6. Accountability. Minutes will be prepared and forwarded to the PEC. Office of record for ICC minutes is the Directorate of Professional Education and Training (SGT).

Appendix B4 – House Officers Council (HOC)

1. Purpose. The purpose of the House Officer's Council (HOC) shall be to present recommendations and review matters concerning the residency programs, working conditions, duties, and responsibilities of medical and dental officers enrolled in approved professional education programs at David Grant USAF Medical Center, to the Commander and/or residency program directors of DGMC. The council will maintain a voting member on the Professional Education Committee (PEC).

2. Membership.

2.1 The members of the HOC shall consist of one senior and one junior resident from each of the medical/dental residency programs, except the transitional year and dental general practice programs shall have one representative each, and the family practice program will have three (one per year group). Allied health residency programs are invited to designate one representative each.

2.2 His or her department shall excuse each member in order to be in attendance for meetings and designated activities.

3. Officers

3.1 The officers of the HOC shall include Chairperson, Vice-Chairperson and Recorder. They will be elected by a majority vote of the council, and must be from three different residency programs. In the absence of the Chairperson, the Vice-Chairperson shall preside. In the absence of both the Chairperson and the Vice-Chairperson, the Recorder shall preside.

3.2 Term of Office: The Chairperson is limited to one one-year term. Other membership within the HOC is unlimited.

3.3 Duties of Officers;

3.3.1 Chairperson: The Chairperson shall attend all meetings; he/she shall present a report on the progress made and recommendations that were put into effect as a result of the work achieved by the HOC. A formal report shall be presented at the last meeting of the term. He/she shall call each meeting to order, review the minutes of the past meeting, chair the business of the meeting and close the meeting with majority consent of the members present.

3.3.2 Vice-Chairperson: The Vice-Chairperson will assume the duties of the Chair in his/her absence. He/she will serve as the voting council representative to the PEC. In the Vice-Chairperson's absence, the Chairperson or his/her appointed representative will attend the PEC.

3.3.3 Recorder: the Recorder will take minutes at the scheduled meetings, distribute these minutes to all members and perform all ordinary duties of the office. He/she will preside over the HOC in the absence of the Chairperson and Vice-Chairperson.

4. Meetings.

4.1 Meetings will be ordinarily held at mutually agreed time every other month (Jan, Mar, May, Jul, Sep, and Nov) and as needed. The meeting in May will additionally include those residents who have been identified to serve as council members for the next academic year. Transitional year and general dental residency representatives may be selected in July.

4.2 Quorum: Six HOC members in person or by proxy shall constitute a quorum, (which shall be needed for every scheduled meeting).

5. Academic Year. The year shall begin on the first day of July and end on the last day of June in each year.

6. Amendments. Proposed amendments to these bylaws shall be submitted in writing to the HOC through the Recorder at least 30 days prior to the HOC meeting. Proposed amendments shall be presented to the members for their information and subsequent vote. A two-thirds vote of the members, in person or by proxy or unanimous support of members in attendance voting on any proposed amendment shall be required for its adoption.

Appendix C - Evaluation Policy/Procedures - Resident Staff

1. Purpose. This appendix augments the policy and procedures specified in AFI 41-117 for evaluation of graduate medical education residents.
2. Policy. Each resident will receive formal evaluations according to the following schedule and guidelines:
 - 2.1 Periodic/quarterly. The attending physician or dentist will complete an evaluation report within five days of the end of the rotation or at least every three months. This evaluation report will be discussed with the resident by the rater and the resident and rater will sign and date the form to indicate that the discussion was accomplished. For clinical rotations consisting of more than one month on the same service, the report may be submitted at the end of the rotation provided all required counseling is accomplished and recorded.
 - 2.2 Annually. The program director will prepare an annual evaluation of each resident utilizing AF Form 475, *Education/Training Report*, as prescribed by AFI 36-2406. AF Form 494, *Academic/Clinical Evaluation Report*, will also be prepared at this time (except for Advanced Education in General Dentistry residents).
 - 2.3 Final Evaluation. Upon completion of a GME program, a final training report (AF Form 475) will be completed for each resident by the program director as required by AFI 36-2406.
 - 2.4 Each rotation evaluation report will be reviewed by the program director concerned.
 - 2.5 If the resident disagrees with any portion of a rotation evaluation report, he or she may submit a written response setting forth the reasons for disagreement. This response will be reviewed as in 2.4 above and filed in the resident's training record.
 - 2.6 A copy of each rotation evaluation and any response submitted by the resident will be filed in the resident's departmental training record.
 - 2.7 The training record of each resident shall be available for review by the resident at any time, upon his/her request. Upon written request from the resident, a copy of any document in the record will be made available to him/her.
 - 2.8 Appeals to annual and final training reports (AF Form 475) will be processed as provided for in AFI 36-2406.
3. Procedures/Responsibility
 - 3.1 Attending Physician/Dentist:
 - 3.1.1 Is encouraged to conduct frequent one-on-one counseling. The end-of-rotation evaluation counseling with the resident will be documented.
 - 3.1.2 Will document counseling on serious deficiencies and suggested remedial assistance and guidance.
 - 3.1.3 Discusses final rating with resident and obtains signature of resident acknowledging the discussion and rating.

3.1.4 Forwards completed evaluation to chief of service/department chairperson concerned.

3.2 Program Director:

3.2.1 Reviews evaluation reports.

3.2.2 Provides counseling and assistance as required.

3.2.3 Files completed reports in individual training records.

3.2.4 Forward annual training reports to the DME for review.

3.3 DME:

3.3.1 Reviews annual evaluation reports.

3.3.2 Discusses evaluations with program directors, as appropriate.

3.3.3 Provides counseling and assistance as required.

4. Maintenance of Training Records

4.1 Department training records of each resident shall be maintained in the pertinent department during training. Following training, these records will be maintained by the Directorate of Professional Education and Training for 50 years or until medical center deactivation and then will be placed in Air Force storage.

4.2 At a minimum, the permanent resident training record shall consist of one copy of each annual AF Form 494, each annual AF Form 475, a copy of medical or dental school diploma, a copy of the Resident Staff Agreement and a copy of the graduation certificate upon successful completion of DGMC training.

Appendix D - Due Process/Discipline/Probation/Dismissal

1. Purpose. This appendix outlines the policy and procedure for assuring the due process for graduate medical education residents in matters relating to discipline, probation and/or dismissal. The Air Force policy and procedure on due process in these matters is contained in AFI 41-117.
2. Policy. It is the policy of the Air Force Medical Service and this medical center that each graduate medical education resident will be afforded full rights and guarantees of due process as provided for in AFI 41-117 and the *Uniform Code of Military Justice* (UCMJ). Due process means the right to be informed of matters relating to discipline, probation, and/or dismissal and the right to a fair hearing and appeal in such matters.
3. Procedures
 - 3.1 Resident staff will be identified by faculty, program directors or other appropriate individuals and presented to the RAT and/or PEC for review. The RAT and/or PEC will make recommendations to the program director, which may include probation and/or elimination from the residency program.
 - 3.2 If the RAT and/or the PEC recommend delay in completion or termination from the program the DME will immediately notify HQ USAF/DPAME and the Commander.
 - 3.3 If the RAT and/or the PEC recommend delay in completion or termination from the program, the DME will notify the resident of his/her right to a formal hearing by a faculty board as provided by AFI 41-117.
 - 3.4 If the medical group commander approves a recommendation for delay in completion or termination from the program, the records of the case will be referred to HQ AFPC/DPAM, Randolph AFB, TX, for review and final decision.

Appendix E – Annual Program Update

1. Annual Report Due to DME on 1 Sep.
2. Required Items:
 - 2.1 Report the results for the past five years of all in-service or other examinations used to evaluate student progress
 - 2.2 Report the board examination results for all program graduates for the past five years
 - 2.3 Report compliance with ACGME work hour policy
 - 2.4 Address previous RRC citations and concerns, potential problem areas in next review
3. DME will consolidate input and report at Sep PEC meeting
4. Annual Review of Resident Staff by HOC
 - 4.1 To better assess the residency program from the resident staff's perspective, the HOC will interview or survey the residents from each residency program. The feedback from the HOC will be presented to the PEC.

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Appendix F – Mid-Cycle Review of Residency Program

1. In accordance with the *Institutional Requirements of Accredited Residencies* (Section I.B.3.c), and as per the policy of the Professional Education Committee, an internal review is required at the mid-point between a residency program's scheduled ACGME Residency Review Committee (RRC) program survey. Normally the review should be not later than one year prior to the site visit. The DME will schedule the review and provide administrative support. A mid-cycle review committee conducts the review with a summary report due to the PEC within 60 days. The PEC forwards the report to the Commander for review.
2. Each mid-cycle review committee will consist of a minimum of three members. The Director of Medical Education (DME) or the designee, a program director or designee from another internal residency program (Chairman), and a senior resident selected by the DME. The DME has the option of appointing a program director or designee from an external residency program in the same specialty being reviewed as an additional member.
3. The mid-cycle review committee will review
 - 3.1 Institutional and program requirements for the specialties of the ACGME RRC from the *Essentials of Accredited Residency Programs*;
 - 3.2 Letters of accreditation from previous ACGME reviews;
 - 3.3 Annual Program Director Reports or Program Updates (previous two years)
 - 3.4 All in-service exam results of the present resident staff
 - 3.5 Mid-Cycle Review Program Director Report
 - 3.6 Residency Program Procedure Manual
 - 3.7 Flight/Residency Education Committee minutes
 - 3.8 Training Affiliation Agreements/Program Director Letters of Agreement
4. The mid-cycle review committee will interview
 - 4.1 At least one resident from each year group in the program
 - 4.2 The program director, faculty and individuals outside the program deemed appropriate.
5. The mid-cycle review committee will appraise:
 - 5.1 The educational objectives of each program;
 - 5.2 The adequacy of available educational and financial resources to meet these objectives;
 - 5.3 The effectiveness of each program in meeting its objectives; and
 - 5.4 The effectiveness in addressing citations from previous ACGME letters of accreditation and previous internal reviews.
6. The mid-cycle review will assess whether the program has defined, in accordance with the relevant Program Requirements, the specific knowledge, skills, and attitudes required and provides educational experiences for the residents to demonstrate competency in the following areas: patient care skills,

medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

7. The mid-cycle review will ensure that the program provides evidence of the program's use of evaluation tools to ensure that the residents demonstrate competence in each of the six areas.

8. The mid-cycle review will appraise the development and use of dependable outcome measures by the program for each of the general competencies.

8.1 The use of dependable measures to assess residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice as defined in the ACGME *Institutional Requirements*; and,

8.2 The effectiveness of each program in implementing a process that links educational outcomes with program improvement.

8.3 The resident staff's faculty/program evaluations for the preceding two years.

9. The mid-cycle review committee will report their findings through the PEC to the Commander. Follow-up action will be tracked through the PEC.

9.1 The mid-cycle report will:

9.1.1 Verify the existence of a curriculum with goals and objectives provided for several of the general competencies;

9.1.2 Summarize/list the types of evaluation tools used by the program for evaluating the competencies;

9.1.3 Comment on the program's status in the development and use of dependable measures to assess resident competency in the six areas;

9.1.4 Comment on the program's status in developing a process that links educational outcomes with program improvement;

9.1.5 Verify/confirm from the residents the existence of a curriculum with goals and objectives for teaching the competencies, their involvement in the curriculum, and the kinds of tools used by the program to evaluate them.

Program Director Report

1. In anticipation of the ACGME site visit, a mid-cycle review committee will be appointed to review the residency program. In preparation for the review, the program director will:
 - 1.1 Prepare a written response to the Program Review Document. The written response is due to the DME within 30 days of receipt of the notification of review.
 - 1.2 Meet with the Mid-Cycle Review Committee to review the ACGME “Green Book” requirements for the program. In addition, the program director will review the Program Review Document with the committee.
2. The program director should attend the PEC meeting at which the Mid-Cycle Review Committee report is presented.

Program Review Document

Residency Program:

Residency Program Director:

Number of Trainees:

Male:

Female:

Number of USUHS Grads:

Number of HPSP Grads:

Number from AD assignments:

Number of AOA Members:

Number of Faculty:

1. Please outline your program objectives (your personal and ACGME mandated). Describe how you monitor the success or failure in meeting these objectives.
2. Who establishes the program’s curriculum? (Chair, Program Director, Faculty Committee, Faculty/Resident Committee, Faculty & Resident Staff, Other)
3. How often is the curriculum formally reviewed?
4. Who conducts the formal curriculum review? (Chair, Program Director, Faculty Committee, Faculty/Resident Committee, Faculty & Resident Staff, Other)
5. Number of resident staff in the past year who:
 - 5.1 Received unfavorable academic reviews
 - 5.2 Complained of or were noted to have symptoms of emotional difficulty
 - 5.3 Complained of severe family stresses
 - 5.4 Were identified with substance abuse issues
 - 5.5 Exhibited inappropriate behavior to patients

- 5.6 Exhibited sexually inappropriate behavior
- 5.7 Had excessive financial stress
- 5.8 Exhibited difficulty with cultural adjustment
6. If there have been problems, what types of problems were encountered?
7. How many trainees have had disciplinary action taken against them in the past two years? Please specify.
8. Of the trainees finishing your program over the last five years, what did they do after graduation?
 - 8.1 Academic/research
 - 8.2 Fellowship
 - 8.3 Field assignment in specialty
9. Of the trainees finishing your program over the last five years, what percentage:
 - 9.1 Board certified (when eligible)
 - 9.2 Failed attempts at board certification
 - 9.3 If your program participates in in-service exams, for the last five years, how have your trainees fared in comparison to the national average?
10. Do you anticipate a decline in the number of applicants to your program?
11. How does this decline compare relative to other programs in your specialty?
12. Has your program had any difficulty in recruiting trainees?
13. What was the date of your last RRC Review and what was the outcome?
14. Does the program have a written policy regarding call schedules and duty hours that are in compliance with ACGME program requirements? Provide a policy and copies of the call schedules for the last six months.
15. Document program's formal written policies regarding residency duty hours, back-up support and on-call schedules. Please describe how these policies are monitored.
16. Provide adequate evidence of a curriculum, complete with goals and objectives, that is used by the program for teaching the following six general competencies:
 - 16.1 Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
 - 16.2 Medical knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
 - 16.3 Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

16.4 Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals

16.5 Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population and

16.6 Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

17. What tools have been developed to evaluate resident competencies in the six areas?

17.1 Provide a list of the evaluation tools being used for each of the six competencies and documented evidence of usage of these tools.

18. Evidence of developing or using dependable measures to assess the residents' competence in each of the six competency areas.

19. Evidence of a process developed to link educational outcomes with program improvement.

20. In addition, does the program ensure that residents achieve the following:

20.1 Develop a personal program of learning to foster continued professional growth with guidance from the teaching staff. Describe how.

20.2 Participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students. Describe how.

20.3 Participate in appropriate institutional committees and councils whose actions affect their education and/or patient care. Describe how.

20.4 Submit to the program director or to designated institutional official at least annually confidential written evaluations of the faculty and of the educational experiences. Describe how.

21. Please describe resident participation and instruction in program's formal quality assurance/performance improvement programs.

22. Describe how the program ensures that resident staff participates in safe, effective and compassionate patient care, under supervision, commensurate with their level of advancement and responsibility.

23. Describe how the program ensures that resident staff assumes responsibility for teaching and supervising other resident staff and medical students.

24. Describe how the program ensures that resident staff participates as appropriate in institutional programs and medical staff activities.

25. Describe how the program ensures that resident staff become aware of and adhere to program content, expectations and policies.

26. Describe how the program ensures that the teaching staff properly supervises the resident staff.
27. Provide a copy of the written description of the role; responsibilities, and patient care activities of each level of resident.
28. Describe how the program evaluates the resident staff. Please provide documentation of any and all evaluation materials.
29. Describe any educational programs available for resident staff to learn about and how to handle the different types of physician impairment and substance abuse.
30. Describe how the program director monitors the activity of the resident staff while assigned to affiliate institutions.
31. If your program was cited by the ACGME and these citations were not addressed in any of the above answers, please provide a description here of what you are doing or have done to correct these deficiencies.
32. Do you have any specific institutional requests that would help you achieve your objectives?
33. Do you have formal written criteria and processes for the selection, evaluation, promotion and dismissal of resident staff in compliance with both the Institutional and relevant program requirements?
34. Summarize particular strengths of the residency program
35. Summarize weaknesses of the program and include your proposed plan of correction.

**Appendix G – Resident Staff Agreement
Transitional Year Residency**

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The Transitional Year Residency is a one-year coordinated medical education program that involves training in all of the major clinical disciplines of medicine, pediatrics, OB/Gyn and surgery, as specified in the curriculum. Upon satisfactory completion of this residency program, the physician is eligible for practice as a general medical officer (AFSC 44G1) or, with completion of the Aerospace Medicine Primary Course, as a flight surgeon (AFSC 48G1), or for further graduate medical education in a medical specialty.

The 60th Medical Group accepts the following physician as a transitional year resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____
2. Hospital: The majority of the resident’s training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.
3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H that is part of the *60th Medical Group GME Policy* (copy attached).
4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.
5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:
 - A. In the case of incapacitating illness or injury of the resident.
 - B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
 - C. Military emergency that would prevent the continuation of this residency program.

6. Absence from duty beyond that allowed by the residency review committee would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

Resident

Date

Program Director

Date

Director, Medical Education

Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

**Appendix G - Resident Staff Agreement
Family Practice Residency**

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The Family Practice Residency is a three-year coordinated medical education program that involves training in all clinical disciplines of family practice. Upon satisfactory completion of this residency program and recommendation by the program director, the physician is eligible for examination by the American Board of Family Practice for certification.

The 60th Medical Group accepts the following physician as a family practice resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____
2. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.
3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H of the *60th Medical Group GME Policy* (copy attached).
4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.
5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:
 - A. In the case of incapacitating illness or injury of the resident.
 - B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
 - C. Military emergency which would prevent the continuation of this residency program
6. In the interest of continuity of the Family Practice Residency, the resident agrees to inform the program director, in writing, of a decision to withdraw from the program. Such notification should be given after due consultation with appropriate staff counselors.

7. It is understood that appointment to a subsequent residency year is contingent upon the good academic standing and performance of the resident as determined by the program director under the conditions specified in the 60th Medical Group GME Policy, the guidelines of the ACGME and AFI 41-117.

8. It is further understood that voluntary withdrawal from the Family Practice Residency before the completion of the first year of the residency will result in a new assignment of duties determined by the HQ AFPC/DPAM.

9. Absence from duty beyond that allowed by the residency review committee would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

_____	_____
Resident	Date
_____	_____
Program Director	Date
_____	_____
Director, Medical Education	Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

**Appendix G - Resident Staff Agreement
General Surgery Residency**

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The General Surgery Residency is a fully accredited five-year training program that provides in-depth exposure to general surgery and all related sub-specialties so as to finish a well-rounded general surgeon (AFSC 45S3). Upon satisfactory completion of this residency program and recommendation of the program director, the physician is eligible for examination by the American Board of Surgery for certification.

The 60th Medical Group accepts the following physician as a general surgery resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____
2. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.
3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H that is part of the *60th Medical Group GME Policy*.
4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.
5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:
 - A. In the case of incapacitating illness or injury of the resident.
 - B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
 - C. Military emergency that would prevent the continuation of this residency program.
6. In the interest of continuity of the General Surgery Residency, the resident agrees to inform the program director, in writing, of a decision to withdraw from the program. Such notification should be given after due consultation with appropriate staff counselors.

7. It is understood that appointment to a subsequent residency year is contingent upon the good academic standing and performance of the resident as determined by the program director under the conditions specified in the 60th Medical Group GME Policy, the guidelines of the ACGME and AFI 41-117.

8. It is understood that for the resident anticipating completion of the training in general surgery, it may be necessary for them to elect to spend a year in clinical investigations (research), and it may mean an additional year of Air Force commitment.

9. It is further understood that voluntary withdrawal from the residency before the completion of the first year of the residency will result in a new assignment of duties determined by the HQ AFPC/DPAM.

10. Absence from duty beyond that allowed by the residency review committee would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

_____ Resident	_____ Date
_____ Program Director	_____ Date
_____ Director, Medical Education	_____ Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

Appendix G - Resident Staff Agreement General Surgery Preliminary Year Residency

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The General Surgery Residency is a fully accredited one-year training program that provides exposure to general surgery and related sub-specialties as well as an orientation into clinical medicine. Upon satisfactory completion of this residency program, the physician is eligible for practice as a general medical officer (AFSC 44G3) or, with completion of the Aerospace Medicine Primary Course, as a flight surgeon (AFSC 48G3), or for further graduate medical education in a medical or surgical specialty.

The 60th Medical Group accepts the following physician as a general surgery preliminary year resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____
2. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.
3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H that is part of the *60th Medical Group GME Policy*.
4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.
5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:
 - A. In the case of incapacitating illness or injury of the resident.
 - B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
 - C. Military emergency that would prevent the continuation of this residency program.
6. In the interest of continuity of the General Surgery Residency, the resident agrees to inform the program director, in writing, of a decision to withdraw from the program. Such notification should be given after due consultation with appropriate staff counselors.

7. It is further understood that voluntary withdrawal from the residency before the completion of the first year of the residency will result in a new assignment of duties determined by the HQ AFPC/DPAM.

8. Absence from duty beyond that allowed by the residency review committee would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

_____ Resident	_____ Date
_____ Program Director	_____ Date
_____ Director, Medical Education	_____ Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

**Appendix G - Resident Staff Agreement
Surgery Clinical Research Fellowship**

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The Surgery Clinical Research Fellowship is a fully accredited one-year training program that provides exposure to the clinical investigation facility, general surgery and related sub-specialties. Upon satisfactory completion of this research fellowship, the physician will continue his General Surgery Residency. so as to finish a well-rounded general surgeon (AFSC 45S3). Upon satisfactory completion of the General Surgery residency program and recommendation of the program director, the physician is eligible for examination by the American Board of Surgery for certification.

The 60th Medical Group accepts the following physician as a surgery clinical research resident under the conditions specified in the agreement.

Rank	Name	SSAN
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9. Duration: Begins on _____ through _____

10. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.

11. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H that is part of the *60th Medical Group GME Policy*.

12. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.

13. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:

- A. In the case of incapacitating illness or injury of the resident.
- B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
- C. Military emergency that would prevent the continuation of this residency program.

14. In the interest of continuity of the Surgery Clinical Research Fellowship, the resident agrees to inform the program director, in writing, of a decision to withdraw from the program. Such notification should be given after due consultation with appropriate staff counselors.

15. It is understood that appointment to a subsequent residency year is contingent upon the good academic standing and performance of the resident as determined by the program director under the conditions specified in the 60th Medical Group GME Policy, the guidelines of the ACGME and AFI 41-117.

16. It is understood that this year in clinical investigations (research) may mean an additional year of Air Force commitment.

17. It is further understood that voluntary withdrawal from the residency before the completion of the residency will result in a new assignment of duties determined by the HQ AFPC/DPAM.

18. Absence from duty beyond that allowed by the residency review committee would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

_____ Resident	_____ Date
_____ Program Director	_____ Date
_____ Director, Medical Education	_____ Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

**Appendix G - Resident Staff Agreement
Internal Medicine Residency**

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The Internal Medicine Residency is an accredited three-year program designed to train a well-rounded general internist. Upon satisfactory completion of this residency program and recommendation of the program director, the physician is eligible for examination by the American Board of Internal Medicine for certification.

The 60th Medical Group accepts the following physician as an internal medicine resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____
2. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.
3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H of the *60th Medical Group GME Policy* (copy attached).
4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.
5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:
 - A. In the case of incapacitating illness or injury of the resident.
 - B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
 - C. Military emergency that would prevent the continuation of this residency program.
6. In the interest of continuity of the Internal Medicine Residency, the resident agrees to inform the program director, in writing, of a decision to withdraw from the program. Such notification should be given after due consultation with appropriate staff counselors.

7. It is understood that appointment to a subsequent residency year is contingent upon the good academic standing and performance of the resident as determined by the program director under the conditions specified in the 60th Medical Group GME Policy, the guidelines of the ACGME and AFI 41-117.

8. It is further understood that voluntary withdrawal from the residency before the completion of the first year of the residency will result in a new assignment of duties determined by the HQ AFPC/DPAM.

9. Absence from duty beyond that allowed by the residency review committee would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

_____ Resident	_____ Date
_____ Program Director	_____ Date
_____ Director, Medical Education	_____ Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

**Appendix G - Resident Staff Agreement
Obstetrics and Gynecology**

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The Obstetrics and Gynecology Residency comprises four years of training. Upon satisfactory completion of this residency program and the recommendation of the program director, the physician is eligible for examination by the American Board of Obstetrics and Gynecology for certification.

The 60th Medical Group accepts the following physician as an obstetrics/ gynecology resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____
2. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.
3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H of the *60th Medical Group GME Policy* (copy attached).
4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.
5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:
 - A. In the case of incapacitating illness or injury of the resident.
 - B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
 - C. Military emergency that would prevent the continuation of this residency program.
6. In the interest of continuity of the Obstetrics/Gynecology Residency, the resident agrees to inform the program director, in writing, of a decision to withdraw from the program. Such notification should be given after due consultation with appropriate staff counselors.
7. It is understood that appointment to a subsequent residency year is contingent upon the good academic standing and performance of the resident as

determined by the program director under the conditions specified in the 60th Medical Group GME Policy, the guidelines of the ACGME and AFI 41-117.

8. It is further understood that voluntary withdrawal from the residency before the completion of the first year of the residency will result in a new assignment of duties determined by the HQ AFPC/DPAM.

9. Absence from duty beyond that allowed by the residency review committee would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

Resident

Date

Program Director

Date

Director, Medical Education

Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

**Appendix G - Resident Staff Agreement
Pediatrics Residency**

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The Pediatrics Residency is a fully accredited three-year program that provides excellent clinical training for prospective pediatricians. Upon satisfactory completion of this residency program and the recommendation of the program director, the physician is eligible for examination by the American Board of Pediatrics for certification.

The 60th Medical Group accepts the following physician as a pediatric resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____
2. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.
3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H of the *60th Medical Group GME Policy* (copy attached).
4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.
5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:
 - A. In the case of incapacitating illness or injury of the resident.
 - B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
 - C. Military emergency that would prevent the continuation of this residency program.
6. In the interest of continuity of the Pediatric Residency, the resident agrees to inform the program director, in writing, of a decision to withdraw from the program. Such notification should be given after due consultation with appropriate staff counselors.

7. It is understood that appointment to a subsequent residency year is contingent upon the good academic standing and performance of the resident as determined by the program director under the conditions specified in the 60th Medical Group GME Policy, the guidelines of the ACGME and AFI 41-117.

8. It is further understood that voluntary withdrawal from the residency before the completion of the first year of the residency will result in a new assignment of duties determined by the HQ AFPC/DPAM.

9. Absence from duty beyond that allowed by the residency review committee would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

_____ Resident	_____ Date
_____ Program Director	_____ Date
_____ Director, Medical Education	_____ Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

Appendix G - Resident Staff Agreement Diagnostic Radiology

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The Diagnostic Radiology residency consists of four (PG-2 to 5) years of training in diagnostic radiology and its subspecialties and in nuclear medicine. Upon satisfactory completion of this residency program and the recommendation of the program director, the physician is eligible for examination by the American Board of Radiology for certification.

The 60th Medical Group accepts the following physician as a diagnostic radiology resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____
2. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.
3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H of the *60th Medical Group GME Policy* (copy attached).
4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.
5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:
 - A. In the case of incapacitating illness or injury of the resident.
 - B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
 - C. Military emergency that would prevent the continuation of this residency program.
6. In the interest of continuity of the Diagnostic Radiology Residency, the resident agrees to inform the program director, in writing, of a decision to withdraw from the program. Such notification should be given after due consultation with appropriate staff counselors.

7. It is understood that appointment to a subsequent residency year is contingent upon the good academic standing and performance of the resident as determined by the program director under the conditions specified in the 60th Medical Group GME Policy, the guidelines of the ACGME and AFI 41-117.

8. It is further understood that voluntary withdrawal from the residency before the completion of the first year of the residency will result in a new assignment of duties determined by the HQ AFPC/DPAM.

9. Absence from duty beyond that allowed by the residency review committee would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

_____ Resident	_____ Date
_____ Program Director	_____ Date
_____ Director, Medical Education	_____ Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

**Appendix G - Resident Staff Agreement
Advanced Education In General Dentistry
Residency**

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The Advanced Education Program in General Dentistry (AEGD) is a 12-month coordinated medical-dental education program which involves training in the major dental disciplines of oral and maxillofacial surgery, prosthodontics, periodontics, restorative dentistry, endodontics, orthodontics, pediatric dentistry, and oral pathology. Upon satisfactory completion of the program, the AEGD resident is eligible to practice as a general clinical dentist (AFSC 47G3C).

The 60th Medical Group accepts the following dentist as an AEGD resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____

2. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.

3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H of the *60th Medical Group GME Policy* (copy attached).

4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.

5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:

- A. In the case of incapacitating illness or injury of the resident.
- B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
- C. Military emergency that would prevent the continuation of this residency program.

6. Absence from duty beyond that allowed by the ADA Council on Education would require an extension of the graduation date. This would include sickness, injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

Resident

Date

Program Director

Date

Director, Medical Education

Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

Appendix G - Resident Staff Agreement Oral And Maxillofacial Surgery Residency

**David Grant USAF Medical Center
60th Medical Group
Travis Air Force Base, California**

The Oral and Maxillofacial Surgery Residency is a 48-month coordinated medical-surgical education program which involves training in all the major clinical disciplines of oral and maxillofacial surgery, medicine, general surgery, plastic and reconstructive surgery, otorhinolaryngology, neurosurgery and emergency room medicine as specified in the Curriculum. Upon satisfactory completion of the program and recommendation by the program director the oral surgery resident is eligible to practice oral and maxillofacial surgery (AFSC 47S3), and is eligible for examination by the American Board of Oral and Maxillofacial Surgery for certification.

The 60th Medical Group accepts the following dentist as an oral and maxillofacial surgery resident under the conditions specified in the agreement.

Rank	Name	SSAN
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1. Duration: Begins on _____ through _____
2. Hospital: The majority of the resident's training will be provided at 60th Medical Group. Required and elective rotations may be taken at other affiliated facilities as specified in the Curriculum.
3. 60th Medical Group agrees to fulfill its responsibility as outlined in Appendix H of the *60th Medical Group GME Policy* (copy attached).
4. The resident agrees to fulfill his/her responsibilities as outlined in Appendix H.
5. The parties have entered into this agreement in good faith and acknowledge the respective moral and legal obligations to fulfill this agreement until its expiration date except:
 - A. In the case of incapacitating illness or injury of the resident.
 - B. In the case of unsatisfactory performance as determined by the program director and the Residency Advocacy Team of the 60th Medical Group.
 - C. Military emergency that would prevent the continuation of this residency program.
6. Absence from duty beyond that allowed by the ADA Council on Education would require an extension of the graduation date. This would include sickness,

injury, maternity absence, ordinary leave and other reasons as determined by the program director and Residency Advocacy Team. It would not include temporary duty as required or permitted by the program director.

Resident

Date

Program Director

Date

Director, Medical Education

Date

Distribution: (1) Resident
(2) Program Director (Department)
(3) Resident Training Record (Medical Education)

Appendix H - Responsibilities And Benefits

1. Policy. The medical center sponsors nine approved graduate medical education programs:

- 1.1 Family Practice Residency
- 1.2 Pediatrics Residency
- 1.3 General Surgery Residency
- 1.4 Obstetrics-Gynecology Residency
- 1.5 Diagnostic Radiology Residency
- 1.6 Internal Medicine Residency
- 1.7 Transitional Year Residency
- 1.8 Oral and Maxillofacial Surgery Residency
- 1.9 Advanced Education in General Dentistry Residency

2. Purpose. This appendix provides a statement of medical center policy applicable to those individuals with patient care responsibilities who have a degree of Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Surgery, or Doctor of Dental Medicine; and who have been accepted for graduate medical education through the USAF Graduate Medical Education Selection Boards for one of these programs.

2.1 Definitions

2.1.1 The medical center is defined as 60th Medical Group, Travis Air Force Base, California. Although the group consists of six squadrons, the titles 60th Medical Group or David Grant USAF Medical Center (DGMC) will be used, in most instances, throughout this publication.

2.1.2 PG 1-3 - Family Practice Resident. Title for individual formally engaged in an approved graduate medical education program leading to eligibility for certification and to practice as a family practice specialist (AFSC 44F3). Such individuals are referred to as residents, house staff or house officers.

2.1.3 PL 1-3 - Pediatrics Resident. Title for individuals formally engaged in an approved graduate medical education program leading to eligibility for certification and to practice as a pediatrics specialist (AFSC 44K3). Such individuals are referred to as residents, house staff or house officers.

2.1.4 PG 1-5 - General Surgery Resident. Title for individuals formally engaged in an approved graduate medical education program leading to eligibility for certification and to practice as a general surgeon (AFSC 45S3). Preliminary Surgery Residents will be eligible for practice as a general medical officer (AFSC 44G3), or with completion of the Primary Aerospace Medicine Course, as a flight surgeon (AFSC 48G3). Successful completion of the preliminary surgery year also makes the individual eligible for further graduate medical education in a specific specialty. Such individuals are referred to as residents, house staff or house officers.

2.1.5 PG 2 – Surgery Clinical Research Fellowship Resident. Title for individual selected from General Surgery Residency to perform a research year sponsored by the Clinical Investigations Facility. After the research year the individual will complete the general surgery residency as above. Such individual is referred to as resident, house staff or house officer.

2.1.6 PG 1-4 - Obstetrics-Gynecology Resident. Title for individuals formally engaged in an approved graduate medical education program leading to eligibility for certification and to practice as an obstetrician-gynecologist (AFSC 45G3). Such individuals are referred to as residents, house staff or house officers.

2.1.7 PG 2-5 - Diagnostic Radiology Resident. Title for individuals formally engaged in an approved graduate medical education program leading to eligibility for certification and to practice as a diagnostic radiologist specialist (AFSC 44R3). Such individuals are referred to as residents, house staff or house officers.

2.1.8 PG 1-3 - Internal Medicine Resident. Title for individuals formally engaged in an approved graduate medical education program leading to eligibility for certification and to practice as an internal medicine specialist (AFSC 44M3). Such individuals are referred to as residents, house staff or house officers.

2.1.9 PG-1 - Transitional Year Resident. Title for individuals formally engaged in an approved graduate medical education program leading to eligibility for practice as a general medical officer (AFSC 44G3), or with completion of the Primary Aerospace Medicine Course, as a flight surgeon (AFSC 48G3). Successful completion of the transitional year also makes the individual eligible for further graduate medical education in a specific specialty. Such individuals are referred to as residents, house staff or house officers.

2.1.10 PG 1-4 - Oral and Maxillofacial Surgery Resident. Title for individuals formally engaged in an approved graduate dental education program leading to eligibility for the practice of oral and maxillofacial surgery (AFSC 47S3). Successful completion of this 48-month program allows the individual eligibility for examination by the American Board of Oral and Maxillofacial Surgery. Such individuals are referred to as residents, house staff or house officers.

2.1.11 PG-1 - Advanced Education in General Dentistry Resident. Title for individuals formally engaged in an approved graduate dental education program providing the individual practitioner a greater exposure into all the specialties within dentistry. Such individuals are referred to as advanced education in general dentistry (AEGD) residents.

2.2 Responsibilities of the Medical Center

2.2.1 To the extent that the medical center establishes accredited graduate medical education programs, the medical center will use its best efforts to continue the accredited status of the program throughout the education or training period of the resident staff.

2.2.2 The medical center shall use reasonable efforts to provide adequate, safe and sanitary facilities in connection with both educational and clinical programs.

2.2.3 The medical center shall be reasonable in assigning resident staff to activities that are not directly related to their educational training. In this respect, the necessities of military operations and duties will at times prevail over purely educational roles and functions.

2.2.4 The medical center shall provide for adequate resident staff supervision appropriate to each level of training, recognizing that graduate medical education is based on a system of graded responsibility in which the level of resident responsibility increases with years of training.

2.2.5 Resident staff must be supervised by teaching staff in such a way that the trainees assume progressively increasing responsibility for patient care according to their level of training, their ability, and their experience. On-call schedules for teaching staff must be structured to assure that supervision is readily available to a resident on duty. The teaching staff must determine the level of responsibility afforded each resident. Components of supervision include:

2.2.5.1 The supervisor's assessment of the skill level of the resident.

2.2.5.2 The supervisor's comfort level with authorizing independent action.

2.2.5.3 Progressive independence in performing functions together with decreasing frequency of spot-checking. Supervision starts with close supervision; progressively encourage independence as skills are observed.

2.2.5.4 Written evaluation and feedback are considered in the progression levels. At all times, the trainee has access to advice and direction from the supervisor.

2.2.6 To the fullest extent possible, the medical center shall uniformly and equitably apply the published policies and standards affecting the resident staff.

2.2.7 Evaluations of each resident shall be made in accordance with the Graduate Medical Education (GME) Policy of the medical center, AFI 41-117, AFI 36-2406 and other pertinent Air Force instructions.

2.2.8 The medical center maintains the confidentiality of the training records of each resident and the consent of the individual is required before access is allowed to such records except where permitted or required by law, Air Force instruction or in the administration of the residency program. Any resident may inspect his/her training records in accordance with the medical center GME policy and pertinent Air Force instructions.

2.2.9 Resident staff shall have reasonable access to the program director, the Director of Medical Education (DME) and the Medical Group Commander (or their designees) for the purpose of informally discussing and resolving issues of mutual interest.

2.2.10 The Medical Library shall be available to the resident staff. Access to the Medical Library for study and research after duty hours will be permitted. Reasonable photocopy privileges for the resident's personal study and use, within the boundaries of the Copyright Law, shall be made available without cost to the resident staff. Medical illustration and medical photography support

services and the use of audiovisual hardware and software in support of the resident staff's educational needs shall be made available.

2.2.11 Funds for temporary duty (TDY) at off-site clinical rotations prescribed in the curriculum will be provided from medical center funds at rates currently authorized by Air Force instructions (see para 4.10 of the DGMC GME Policy).

2.3 Responsibilities of the Resident Staff

2.3.1 Each resident is expected to fulfill the clinical and educational requirements of the graduate medical education and graduate clinical residency program in which he/she is enrolled. Such clinical and educational requirements include the teaching of medical students, hospital staff and other residents.

2.3.2 Each resident is expected to provide safe, effective, and compassionate patient care under supervision.

2.3.3 Each resident is expected to comply with the published *Principles of Medical Ethics* of the American Medical Association and is subject to the *Uniform Code of Military Justice*, and the rules and instructions of the U.S. Air Force and the medical center. When assigned to rotations at affiliated institutions, each resident shall comply with the published rules and regulations of that institution provided that they do not conflict with the rules and instructions of the U.S. Air Force.

2.3.4 Each medical resident shall complete the United States Medical Licensing Examination (USMLE) Step 3, or Comprehensive Osteopathic Medical Licensure Examination (COMLEX), as appropriate, at the earliest opportunity but not later than 15 March, during the PG-1 year. An unrestricted state medical license shall be obtained not later than the end of the PG-2 year. Residents who only receive one year of initial training must apply for an unrestricted state license as soon as possible during their PG-1 year. Residents who entered the residency programs with a valid state license must retain an unrestricted state medical license while in their residency programs.

2.3.5 Each resident will participate in programs, activities and committees of the medical staff; especially those that relate to patient care review. Resident staff will attend scheduled department service meetings and teaching activities while assigned to specific clinical rotations. They will attend scheduled conferences not conflicting with requirements of specific clinical rotations.

2.3.6 Each resident is required to maintain accurate and complete patient medical records in a timely manner as required by AFI 41-210 and medical center policies and instructions.

2.3.7 Each resident is expected to apply cost containment measures in the provision of patient care.

2.3.8 Each resident will fulfill officership responsibilities regarding appearance (AFI 36-2903), weight restrictions (AFI 40-502), military bearing, military readiness requirements, immunizations, mandatory formations and aerobics.

2.3.9 Sexual harassment or inappropriate fraternization will not be tolerated. The Air Force has high standards and we expect our members to uphold them. All

members are encouraged to report violations either through their chain of command or any number of outside agencies to include:

2.3.9.1 Chaplain's Office

2.3.9.2 Social Actions Office

2.3.9.3 Inspector General's Office

2.3.9.4 1-800-HOTLINE (HQ AFPC)

2.3.10 Outside employment ("moonlighting") by resident staff is absolutely prohibited.

2.4 Appointment and Reappointment

2.4.1 Resident staff are appointed to a sponsored program at the medical center are appointed for the full duration of the program and no formal reappointment is required provided that the resident is making satisfactory progress in his/her program.

2.4.2 Residents shall progress from one postgraduate level to the next level unless:

2.4.2.1 He/she is released from the program, or

2.4.2.2 His/her performance is determined to be below standard by his/her program director after following the procedures prescribed in para 4.4.7 and Appendix D, Due Process.

2.5 Compensation. Compensation for resident staff is determined, as for all Air Force officers, by public law and detailed in appropriate Air Force instructions. The Air Force Accounting and Finance Center shall provide each resident a detailed record of pay and compensation at the end of each established pay period. Resident staff shall be provided assistance by the program director, DME or Administrator in clarifying and rectifying pay matters.

2.6 Duty Hours. Resident staff duty hours will be scheduled to maximize education and patient safety while minimizing stress and fatigue. Duty hours must meet the guidelines of the ACGME. To the maximum extent possible, the following objectives will be met:

2.6.1 Intense and demanding rotations will not be scheduled back-to-back during the course of the academic year.

2.6.2 On the average over the academic year, in-house call will be no more frequent than every third night.

2.6.3 Residents will average one 24-hour break from patient care over each 7-day period during a four-week rotation.

2.6.4 Palliative measures will be taken when resident workload becomes excessive, in terms of either number or intensity.

2.6.5 Others, as prescribed by Special Requirements of the ACGME.

2.7 Scheduling.

2.7.1 All call schedules shall be accurately kept and made available to the resident staff.

2.7.2 Residents shall be permitted to exchange schedules with each other provided that proper coverage is provided and upon advance approval of the appropriate chief of service and the program director.

2.7.3 The resident making the exchange of schedule remains responsible for coverage of that specific call.

2.8 Leave Policy.

2.8.1 Ordinary leave is to be scheduled by mutual agreement between the resident, chief of service and program director.

2.8.2 Leave for resident staff, by postgraduate level, is ordinarily granted as follows:

2.8.2.1 PG-1 (and all OMS residents): up to 21 days, including weekends and holidays.

2.8.2.2 PG-2: 21 days, including weekends and holidays.

2.8.2.3 PG-3-5: 30 days, including weekends and holidays.

2.8.3 Residents are encouraged to submit a proposed leave schedule in July of each year for planning purposes and to assure that leave can be equitably scheduled and still meet program needs and clinical service rotation needs.

2.8.4 The resident, the chief of service/attending physician and the program director shall mutually agree upon the number of days of leave taken at any one time. Scheduled and approved leave must be taken as programmed, unless emergency situations intervene on the part of the resident or the program.

2.8.5 As active duty military members, residents do not earn sick leave, per se. Periods of hospitalization or "quarters" status for illness or injury are authorized as provided for in applicable Air Force instructions. Resident staff will comply with medical center policy concerning excuse from duty due to illness or injury. This policy requires that active duty military personnel, not fit for duty as a result of illness or injury, must be seen by a staff physician of the medical center. When appropriate, the military member will be issued a duty excuse for a period of not more than 24 hours or be admitted officially to the hospital or "quarters" status. Residents will notify the program director and chief of service/attending physician whenever they are officially excused from duty by reason of illness or injury.

2.8.6 Any time away from the residency program for any other reason, such as sick leave (excluding brief absences) or additional emergency leave, will be made up in a similar fashion as described in the Family Leave Policy below.

2.8.7 Residents who have confirmed permanent change of station (PCS) orders may be granted up to ten days of permissive temporary duty (TDY) for the purpose of securing housing in the area of their new assignment. Such absence will be granted after coordination and approval through the chief of service/attending physician of the service concerned and the program director. Final approval for permissive TDY for house hunting purposes rests with the appropriate squadron commander.

2.9 Family Leave Policy

2.9.1 Maternity leave will be granted to residents as authorized in current Air Force instructions. The length of the maternity leave, plus the length of time away from the residency program due to prenatal medical restrictions (bed rest, etc) and due to hospitalization during pregnancy and the postpartum period, will generally be made up at the end of the original training period. The resident may take additional regular AF leave appended to the maternity leave, up to two weeks duration.

2.9.2 It may be possible to use annual leave, elective rotations and/or additional "call" to make up lost time, but that is not required. The program director will coordinate through the DME and HQ AFPC/DPAME to obtain an extension to the graduation date as appropriate to meet RRC guidelines.

2.9.3 During the remainder of the residency program, the resident will continue to take call at the same frequency as her peers. Also, she will continue to take call during the additional time added to the training period.

2.9.4 Similar policy will apply to a resident who is the primary caregiver, male or female, of a newly adopted child under six years of age.

2.9.5 A resident who is not the primary caregiver for a newly born child or adopted child, may take up to two weeks leave which will be counted against the leave allowed during training.

2.10 Training Record/Discipline/Dismissal and Due Process

2.10.1 The training record of each resident will be maintained as prescribed in AFI 41-117 and the GME Policy of the Medical Center.

2.10.2 Discipline/Dismissal and Due Process are covered in para 4.4.7 and Appendix D, GME Policy.

2.11 Benefits

2.11.1 Benefits for resident staff shall be the same as those afforded by public law and Air Force instructions for all active duty military personnel. AFI 48-123, *Medical Examinations and Standards*, govern the process for determining fitness for duty and disability determinations.

2.11.2 Professional liability coverage for resident staff performing health care duties shall be as provided by the Westfall Act, Title 28 USC, Section 2679.

2.11.3 Parking is available at no cost as provided for in medical center rules and instructions.

2.11.4 Hospital utility clothing (clinical coats, scrub suits) shall be provided by the medical center at no cost. Required items of military uniform clothing will be the responsibility of the resident staff.

2.11.5 Frequent periodic counseling will be provided for residents by the attending teaching staff, program directors and/or the DME to assist residents with adjustments to the demand and stresses of the residency. Where desirable, counseling and psychological support through mental health professionals will be made available to residents.

2.12 Residency Closure/Reduction. In the event of a reduction or closure of a program, the residents will be allowed to complete their education or will be assisted in enrolling in an ACGME accredited program in which they can continue their education.

3. Policy and Procedure Document Review. The policy and procedures expressed herein will be reviewed annually by the program directors, DME, Chief of the Medical Staff, Professional Education Committee, Residency Advocacy Team, and Executive Committee of the medical center.