Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
Int.A.	Definition of Graduate Medical Education Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.	[None]	Definition of Graduate Medical Educati Graduate medical education is the crue between medical school and autonome phase of the continuum of medical edu optimal patient care under the supervis instruct, but serve as role models of ex sensitivity, professionalism, and schol Graduate medical education transform scholars who care for the patient, patie create and integrate new knowledge in generations of physicians to serve the during graduate medical education per
Int.A. (Continued)	Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments. Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.	[None] - (Continued)	Graduate medical education has as a c responsibility for patient care. The care appropriate faculty supervision and co residents to attain the knowledge, skill required for autonomous practice. Gra physicians who focus on excellence in affordable, quality care; and the health Graduate medical education values the physicians brings to medical care, and psychologically safe learning environm Graduate medical education occurs in foundation for practice-based and lifel development of the physician, begun it faculty modeling of the effacement of s environment that emphasizes joy in cu rigor, and discovery. This transformati and intellectually demanding and occu environments committed to graduate r of patients, residents, fellows, faculty r of the health care team.

#### ation

rucial step of professional development mous clinical practice. It is in this vital ducation that residents learn to provide vision of faculty members who not only excellence, compassion, cultural olarship.

ms medical students into physician tient's family, and a diverse community; into practice; and educate future ne public. Practice patterns established persist many years later.

a core tenet the graded authority and are of patients is undertaken with conditional independence, allowing tills, attitudes, judgment, and empathy raduate medical education develops in delivery of safe, equitable, th of the populations they serve. The strength that a diverse group of and the importance of inclusive and nments.

in clinical settings that establish the felong learning. The professional a in medical school, continues through f self-interest in a humanistic curiosity, problem-solving, academic ation is often physically, emotionally, curs in a variety of clinical learning e medical education and the well-being y members, students, and all members

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
Int.B.	Definition of Specialty Residency education in internal medicine-pediatrics encompasses integrative training in internal medicine and pediatrics. The combined training allows development of a physician knowledgeable in the full spectrum of human development, from newborns to the aged. It includes the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of infants, children, adolescents, men, and women. The scientific model of problem solving and evidence-based decision making with a commitment to lifelong learning and an attitude of caring derived from humanistic and professional values is integral to the specialty. The combined internal medicine-pediatrics program prepares graduates to provide health care in a broad spectrum of practice that includes primary and subspecialty care and ambulatory and hospital-based care, with additional subspecialty training in urban, rural, and global settings.		<b>Definition of Specialty</b> <i>Residency education in internal medicinitegrative training in internal medicinitraining allows development of a physis spectrum of human development, from the study and practice of health promicare, and treatment of infants, childree The scientific model of problem solvin making with a commitment to lifelong derived from humanistic and profession specialty. The combined internal medicare graduates to provide health care in a includes primary and subspecialty call based care, with additional subspecial settings.</i>
	Length of Educational Program		Length of Program
	The educational program in internal medicine-pediatrics must be 48 months in		The educational program in internal m
Int.C.	length. (Core) Oversight	4.1. Section 1	months in length. (Core) Section 1: Oversight
	<ul> <li>Sponsoring Institution</li> <li>The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.</li> <li>When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site</li> </ul>	[None]	Sponsoring Institution The Sponsoring Institution is the o the ultimate financial and academic graduate medical education, consis Requirements. When the Sponsoring Institution is program, the most commonly utiliz program is the primary clinical site
I.A.	primary clinical site. The program must be sponsored by one ACGME-accredited Sponsoring	[None]	The program must be sponsored b
I.A.1.	Institution. (Core)	1.1.	Sponsoring Institution. (Core)
I.B.	<ul> <li>Participating Sites</li> <li>A participating site is an organization providing educational experiences or educational assignments/rotations for residents.</li> <li>The program, with approval of its Sponsoring Institution, must designate a</li> </ul>	[None]	Participating Sites A participating site is an organizati experiences or educational assign The program, with approval of its S
I.B.1.	primary clinical site. (Core)	1.2.	designate a primary clinical site. (C
I.B.1.a)	Relation to Categorical Residencies	1.2.a.	Relation to Categorical Residencies The four-year combined training in int be provided by ACGME-accredited ca specialties that are sponsored by the Institution and are in close geographic

edicine-pediatrics encompasses cine and pediatrics. The combined hysician knowledgeable in the full from newborns to the aged. It includes bomotion, disease prevention, diagnosis, fren, adolescents, men, and women. ving and evidence-based decision ng learning and an attitude of caring ssional values is integral to the edicine-pediatrics program prepares a broad spectrum of practice that care and ambulatory and hospitalcialty training in urban, rural, and global

medicine-pediatrics must be 48

organization or entity that assumes nic responsibility for a program of sistent with the ACGME Institutional

is not a rotation site for the lized site of clinical activity for the ite.

by one ACGME-accredited

ation providing educational inments/rotations for residents. s Sponsoring Institution, must (Core)

internal medicine and pediatrics must categorical programs in these ne same ACGME-accredited Sponsoring hic proximity. (Core)

atted nt Number	Requiremen
Relation to Categori The four-year comb be provided by ACG specialties that are s Institution and are in	bined training in inf GME-accredited ca sponsored by the
The one exception i children's hospital, i (DIO) of the institutio program or the DIO program may have i (Core)	in which case eithe ion that sponsors t ) of the institution t
The categorical prog medicine-pediatrics	•
The residents in the all levels of training.	e categorical and c
The program director director(s) of the con coordination of curri	ombined program n
To achieve appropri accountability, inclue discipline, the progra program director(s) meetings that involv well as internal med departments. (Detai	uding integration of ram directors of the of the combined p ve consultation with dicine-pediatrics re
There must be a pr program and each between the progra assignment. (Core	n participating site ram and the partie
The PLA must be r	renewed at least
The PLA must be a (DIO). (Core)	
The program must environment at all	
At each participation designated by the accountable for rea the program direct	e program director esident education
The program direc participating sites required for all res	s routinely providi sidents, of one me
	the program direc The program direc participating sites

nternal medicine and pediatrics must categorical programs in these e same ACGME-accredited Sponsoring hic proximity. (Core)

atrics program is sponsored by a her the designated institutional official the internal medicine residency that sponsors the pediatric residency oversight of the combined program.

h participate in only one internal )

combined programs must interact at

l categorical programs and the program must demonstrate collaboration and ions. (Core)

of the combined program and shared of training and supervision in each he categorical programs and the program should hold at least quarterly *i*th faculty from both departments, as residents and/or residents from both

f agreement (PLA) between the ite that governs the relationship ticipating site providing a required

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

inical learning and working ites. (Core)

ust be one faculty member, for as the site director, who is on at that site, in collaboration with

it any additions or deletions of ding an educational experience, month full time equivalent (FTE) or editation Data System (ADS). (Core)

Roman Numeral Requirement Number	Poquiroment Lenguage	Reformatted	Demuinement Levensers
I.C.	Requirement Language           Workforce Recruitment and Retention           The program, in partnership with its Sponsoring Institution, must engage           in practices that focus on mission-driven, ongoing, systematic recruitment           and retention of a diverse and inclusive workforce of residents, fellows (if           present), faculty members, senior administrative GME staff members, and           other relevant members of its academic community. (Core)	Requirement Number	Requirement Language           Workforce Recruitment and Retention           The program, in partnership with its Sponsoring Institution, must           engage in practices that focus on mission-driven, ongoing,           systematic recruitment and retention of a diverse and inclusive           workforce of residents, fellows (if present), faculty members, senior           administrative GME staff members, and other relevant members of its           academic community. (Core)
I.D.	Resources	1.8.	Resources The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)
I.D.1.	The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)	1.8.	Resources The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)
I.D.1.a)	The Sponsoring Institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of the full spectrum of adult and pediatric patients. (Core)	1.8.a.	The Sponsoring Institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of the full spectrum of adult and pediatric patients. (Core)
I.D.1.b)	Additional services should include those for cardiac catheterization, bronchoscopy, gastrointestinal endoscopy, non-invasive cardiology studies, pulmonary function studies, hemodialysis, and imaging studies, including radionuclide, ultrasound, fluoroscopy, angiography, computerized tomography, and magnetic resonance imaging. (Detail)	1.8.b.	Additional services should include those for cardiac catheterization, bronchoscopy, gastrointestinal endoscopy, non-invasive cardiology studies, pulmonary function studies, hemodialysis, and imaging studies, including radionuclide, ultrasound, fluoroscopy, angiography, computerized tomography, and magnetic resonance imaging. (Detail)
I.D.1.c)	Adequate clinical and teaching space must be available, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, medical and electronic resources to achieve all of the required educational outcomes, and office space for teaching staff. (Core)	1.8.c.	Adequate clinical and teaching space must be available, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, medical and electronic resources to achieve all of the required educational outcomes, and office space for teaching staff. (Core)
l.D.1.d)	In addition to an emergency facility providing care for adults, there must be an emergency facility that specializes in the care of pediatric patients and that receives pediatric patients who have been transported via the Emergency Medical Services system. (Core)	1.8.d.	In addition to an emergency facility providing care for adults, there must be an emergency facility that specializes in the care of pediatric patients and that receives pediatric patients who have been transported via the Emergency Medical Services system. (Core)
I.D.1.e)	There should be services available from other health care professionals such as nurses, social workers, case managers, language interpreters, and dieticians. (Detail)	1.8.e.	There should be services available from other health care professionals such as nurses, social workers, case managers, language interpreters, and dieticians. (Detail)
I.D.1.f)	Consultations from other clinical services should be available in a timely manner in all care settings where the residents work. All consultations should be performed by or under the supervision of a qualified specialist. (Detail)	1.8.f.	Consultations from other clinical services should be available in a timely manner in all care settings where the residents work. All consultations should be performed by or under the supervision of a qualified specialist. (Detail)
I.D.1.g)	The program should provide residents with access to training using simulation. (Detail)	1.8.g.	The program should provide residents with access to training using simulation. (Detail)
I.D.1.h)	The program must provide access to an electronic health record. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation. (Core)	1.8.h.	The program must provide access to an electronic health record. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
I.D.1.i)	The program must provide a volume, variety, and complexity in diagnoses and age, from infants to geriatric patients, sufficient for residents to achieve all of the required educational outcomes. (Core)	1.8.i.	The program must provide a volume, and age, from infants to geriatric pati- all of the required educational outcom
I.D.2.	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:	1.9.	The program, in partnership with it ensure healthy and safe learning a promote resident well-being and p
I.D.2.a)	access to food while on duty; (Core)	1.9.a.	access to food while on duty; (Cor
I.D.2.b)	safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)	1.9.b.	safe, quiet, clean, and private sleep accessible for residents with proxi care; (Core)
I.D.2.c)	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	clean and private facilities for lacta capabilities, with proximity approp
I.D.2.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures approand, (Core)
I.D.2.e)	accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)	1.9.e.	accommodations for residents with Sponsoring Institution's policy. (Co
I.D.3.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)	1.10.	Residents must have ready access appropriate reference material in pr include access to electronic medic capabilities. (Core)
I.E. II.	Other Learners and Health Care Personnel The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core) Personnel	1.11. Section 2	Other Learners and Health Care Pe The presence of other learners and including, but not limited to resider subspecialty fellows, and advanced negatively impact the appointed resider Section 2: Personnel
II.A.	Program Director	2.1.	Program Director There must be one faculty member with authority and accountability fo compliance with all applicable prog
II.A.1.	There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)	2.1.	Program Director There must be one faculty member with authority and accountability fo compliance with all applicable prog
II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)	2.2.	The Sponsoring Institution's GMEC program director and must verify the and clinical appointment. (Core)
II.A.1.b)	The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)	2.3.	The program must demonstrate ret a length of time adequate to mainta program stability. (Core)
II.A.2.	The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)		The program director and, as appli- team, must be provided with suppo- the program based upon its size ar

e, variety, and complexity in diagnoses tients, sufficient for residents to achieve omes. (Core)

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

ore)

ep/rest facilities available and ximity appropriate for safe patient

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

ith disabilities consistent with the Core)

ss to specialty-specific and other print or electronic format. This must lical literature databases with full text

Personnel

nd other health care personnel, lents from other programs, ced practice providers, must not residents' education. (Core)

er appointed as program director for the overall program, including rogram requirements. (Core)

er appointed as program director for the overall program, including rogram requirements. (Core)

EC must approve a change in the program director's licensure

retention of the program director for name

blicable, the program's leadership port adequate for administration of and configuration. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: (Core)		At a minimum, the program director n time and support specified below for a
	Number of Approved Resident Positions:<7   Minimum Support Required (FTE): 0.2		Number of Approved Resident Position (FTE): 0.2
	Number of Approved Resident Positions:7-10   Minimum Support Required (FTE): 0.4		Number of Approved Resident Position (FTE): 0.4
II.A.2.a)	Number of Approved Resident Positions:>10   Minimum Support Required (FTE): 0.5	2.4.a.	Number of Approved Resident Position (FTE): 0.5
	Programs with more than 15 residents must appoint an associate program director(s). The associate program director(s) must be provided with support equal to a dedicated minimum time for administration of the program as follows: (Core)		Programs with more than 15 resident director(s). The associate program di support equal to a dedicated minimur program as follows: (Core)
	Number of Approved Resident Positions:<15   Minimum Aggregate APD Support Required (FTE): n/a		Number of Approved Resident Position Support Required (FTE): n/a
	Number of Approved Resident Positions:16-20   Minimum Aggregate APD Support Required (FTE): 0.1		Number of Approved Resident Positic Support Required (FTE): 0.1
	Number of Approved Resident Positions:21-25   Minimum Aggregate APD Support Required (FTE): 0.2		Number of Approved Resident Position Support Required (FTE): 0.2
II.A.2.b)		2.4.b.	

r must be provided with the dedicated or administration of the program: (Core)

tions:<7 | Minimum Support Required

tions:7-10 | Minimum Support Required

tions:>10 | Minimum Support Required

nts must appoint an associate program director(s) must be provided with um time for administration of the

tions:<15 | Minimum Aggregate APD

tions:16-20 | Minimum Aggregate APD

tions:21-25 | Minimum Aggregate APD

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	. Requiremer
	Number of Approved Resident Positions:26-30   Minimum Aggregate APD Support Required (FTE): 0.3		Number of Approved Resident Position Support Required (FTE): 0.3
	Number of Approved Resident Positions:31-35   Minimum Aggregate APD Support Required (FTE): 0.4		Number of Approved Resident Position Support Required (FTE): 0.4
	Number of Approved Resident Positions:36-40   Minimum Aggregate APD Support Required (FTE): 0.5		Number of Approved Resident Position Support Required (FTE): 0.5
	Number of Approved Resident Positions:41-45   Minimum Aggregate APD Support Required (FTE): 0.6		Number of Approved Resident Position Support Required (FTE): 0.6
	Number of Approved Resident Positions:46-50   Minimum Aggregate APD Support Required (FTE): 0.7		Number of Approved Resident Position Support Required (FTE): 0.7
	Number of Approved Resident Positions:51-55   Minimum Aggregate APD Support Required (FTE): 0.8		Number of Approved Resident Position Support Required (FTE): 0.8
	Number of Approved Resident Positions:56-60   Minimum Aggregate APD Support Required (FTE): 0.9		Number of Approved Resident Position Support Required (FTE): 0.9
	Number of Approved Resident Positions:61-65   Minimum Aggregate APD Support Required (FTE): 1		Number of Approved Resident Position Support Required (FTE): 1
II.A.2.b) - (Continued)	Number of Approved Resident Positions:> 65   Minimum Aggregate APD Support Required (FTE): 1.1	2.4.b (Continued)	Number of Approved Resident Position Support Required (FTE): 1.1
II.A.3.	Qualifications of the program director:	2.5.	Qualifications of the Program Direc The program director must posses three years of documented educati experience, or qualifications accep (Core)
II.A.3.a)	must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)	2.5.	Qualifications of the Program Direc The program director must posses three years of documented educati experience, or qualifications accep (Core)
11. <i>7</i> .v.aj		2.0.	
	must include current certification in the specialty for which they are the program director by the American Board of Internal Medicine (ABIM) or by the American Osteopathic Board of Internal Medicine, and the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics, or specialty qualifications that are acceptable to the Review Committee; and,		The program director must posses specialty for which they are the pro Board of Internal Medicine (ABIM) or Board of Internal Medicine, and the A the American Osteopathic Board of P
II.A.3.b)	(Core)	2.5.a.	that are acceptable to the Review C

itions:26-30 | Minimum Aggregate APD

itions:31-35 | Minimum Aggregate APD

itions:36-40 | Minimum Aggregate APD

itions:41-45 | Minimum Aggregate APD

itions:46-50 | Minimum Aggregate APD

itions:51-55 | Minimum Aggregate APD

itions:56-60 | Minimum Aggregate APD

itions:61-65 | Minimum Aggregate APD

itions:> 65 | Minimum Aggregate APD

#### rector

ess specialty expertise and at least ational and/or administrative eptable to the Review Committee.

#### rector

ess specialty expertise and at least ational and/or administrative eptable to the Review Committee.

ess current certification in the program director by the American or by the American Osteopathic e American Board of Pediatrics (ABP) or Pediatrics, or specialty qualifications of Committee. (Core)

Roman Numeral Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requirement
II.A.3.c)	must include ongoing clinical activity. (Core)	2.5.b.	The program director must demons (Core)
	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of		Program Director Responsibilities The program director must have res accountability for: administration a scholarly activity; resident recruitm promotion of residents, and discipl
II.A.4.	residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)	2.6.	residents; and resident education in (Core)
II.A.4.a)	The program director must:	[None]	
II.A.4.a).(1)	be a role model of professionalism; (Core)	2.6.a.	The program director must be a role
II.A.4.a).(2)	design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)	2.6.b.	The program director must design a fashion consistent with the needs of the Sponsoring Institution, and the
II.A.4.a).(3)	administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)	2.6.c.	The program director must adminis environment conducive to educatin ACGME Competency domains. (Con
II.A.4.a).(4)	have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)	2.6.d.	The program director must have the physicians and non-physicians as f sites, including the designation of o develop and oversee a process to e approval. (Core)
II.A.4.a).(5)	have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)	2.6.e.	The program director must have the from supervising interactions and/o not meet the standards of the progr
II.A.4.a).(6)	submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)	2.6.f.	The program director must submit a required and requested by the DIO,
II.A.4.a).(7)	provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)	2.6.g.	The program director must provide environment in which residents hav concerns, report mistreatment, and manner as appropriate, without fea (Core)
II.A.4.a).(8)	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; (Core)	2.6.h.	The program director must ensure a Sponsoring Institution's policies ar grievances and due process, incluc suspend or dismiss, or not to prom resident. (Core)
II.A.4.a).(9)	ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)	2.6.i.	The program director must ensure Sponsoring Institution's policies ar non-discrimination. (Core)

ent Language
nstrate ongoing clinical activity.
S
responsibility, authority, and
and operations; teaching and
tment and selection, evaluation, and plinary action; supervision of
in the context of patient care.
ole model of professionalism. (Core)
n and conduct the program in a
s of the community, the mission(s) of
ne mission(s) of the program. (Core)
hister and maintain a learning
ting the residents in each of the Core)
the authority to approve or remove
s faculty members at all participating
of core faculty members, and must o evaluate candidates prior to
evaluate candidates prior to
the authority to remove residents
d/or learning environments that do ogram. (Core)
it accurate and complete information
O, GMEC, and ACGME. (Core)
de a learning and working
have the opportunity to raise nd provide feedback in a confidential
ear of intimidation or retaliation.
e the program's compliance with the
and procedures related to uding when action is taken to
omote or renew the appointment of a
e the program's compliance with the
and procedures on employment and

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
II.A.4.a).(9).(a)	Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Residents must not be required to or restrictive covenant. (Core)
II.A.4.a).(10)	document verification of education for all residents within 30 days of completion of or departure from the program; and, (Core)	2.6.j.	The program director must docume residents within 30 days of comple program. (Core)
II.A.4.a).(11)	provide verification of an individual resident's education upon the resident's request, within 30 days; and (Core)	2.6.k.	The program director must provide resident's education upon the resid (Core)
II.A.4.a).(12)	provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)	2.6.1.	The program director must provide interview with information related t relevant specialty board examination
П.В.	<ul> <li>Faculty</li> <li>Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients.</li> <li>Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning.</li> <li>Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.</li> <li>Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety.</li> <li>Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.</li> </ul>		Faculty Faculty members are a foundational education – faculty members teach patients. Faculty members provide residents to grow and become prace receive the highest quality of care. generations of physicians by demo commitment to excellence in teach professionalism, and a dedication to members experience the pride and development of future colleagues. by the opportunity to teach and mo employing a scholarly approach to through the graduate medical educ of the individual and the population Faculty members ensure that patie expected from a specialist in the first to the needs of the patients, reside Faculty members provide appropria promote patient safety. Faculty me environment by acting in a profess well-being of the residents and the
II.B.1.	There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)	2.7.	There must be a sufficient number competence to instruct and superv
	Pediatric Subspecialty Faculty There must be faculty members with pediatric subspecialty board certification who function on an ongoing basis as integral parts of the clinical and instructional components of the program in both inpatient and outpatient		Pediatric Subspecialty Faculty There must be faculty members with p certification who function on an ongoin clinical and instructional components
II.B.1.a)	settings. (Core)	2.7.a.	outpatient settings. (Core)
II.B.2. II.B.2.a)	Faculty members must: be role models of professionalism; (Core)	[None] 2.8.	Faculty Responsibilities Faculty members must be role mod

o sign a non-competition guarantee

nent verification of education for all letion of or departure from the

de verification of an individual sident's request, within 30 days.

de applicants who are offered an I to the applicant's eligibility for the tion(s). (Core)

anal element of graduate medical ch residents how to care for de an important bridge allowing ractice-ready, ensuring that patients re. They are role models for future monstrating compassion, ching and patient care, n to lifelong learning. Faculty nd joy of fostering the growth and s. The care they provide is enhanced model exemplary behavior. By to patient care, faculty members, ucation system, improve the health ion.

tients receive the level of care field. They recognize and respond dents, community, and institution. briate levels of supervision to nembers create an effective learning ssional manner and attending to the hemselves.

er of faculty members with ervise all residents. (Core)

h pediatric subspecialty board joing basis as integral parts of the ts of the program in both inpatient and

odels of professionalism. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
II.B.2.b)	demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)	2.8.a.	Faculty members must demonstrat safe, equitable, high-quality, cost-e (Core)
II.B.2.c)	demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)	2.8.b.	Faculty members must demonstrat of residents, including devoting sur program to fulfill their supervisory (Core)
II.B.2.d)	administer and maintain an educational environment conducive to educating residents; (Core)	2.8.c.	Faculty members must administer a environment conducive to educatin
II.B.2.e)	regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)	2.8.d.	Faculty members must regularly pa discussions, rounds, journal clubs,
II.B.2.f)	pursue faculty development designed to enhance their skills at least annually: (Core)	2.8.e.	Faculty members must pursue facu enhance their skills at least annual
II.B.2.f).(1)	as educators and evaluators; (Detail)	2.8.e.1.	as educators and evaluators; (Deta
II.B.2.f).(2)	in quality improvement, eliminating health inequities, and patient safety; (Detail)	2.8.e.2.	in quality improvement, eliminating safety; (Detail)
II.B.2.f).(3)	in fostering their own and their residents' well-being; and, (Detail)	2.8.e.3.	in fostering their own and their resi
II.B.2.f).(4)	in patient care based on their practice-based learning and improvement efforts. (Detail)	2.8.e.4.	in patient care based on their pract improvement efforts. (Detail)
II.B.3.	Faculty Qualifications	2.9.	Faculty Qualifications Faculty members must have approp and hold appropriate institutional a
II.B.3.a)	Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)	2.9.	Faculty Qualifications Faculty members must have appropriate institutional a
II.B.3.b)	Physician faculty members must:	[None]	
II.B.3.b).(1)	have current certification in the specialty by the American Board of Internal Medicine (ABIM), the American Board of Pediatrics (ABP) or the American Osteopathic Board of Internal Medicine (AOBIM), or the American Osteopathic Board of Pediatrics (AOBP), or possess qualifications judged acceptable to the Review Committee. (Core)		Physician faculty members must ha specialty by the American Board of American Board of Pediatrics (ABP) o of Internal Medicine (AOBIM), or the A Pediatrics (AOBP), or possess qualit Review Committee. (Core)
II.B.4.	Core Faculty Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)	2.11.	Core Faculty Core faculty members must have a and supervision of residents and m their entire effort to resident educat must, as a component of their activ formative feedback to residents. (C
II.B.4.a)	Core faculty members must complete the annual ACGME Faculty Survey. (Core)	2.11.a.	Core faculty members must comple Survey. (Core)
II.B.4.b)	In addition to the program director, there must be at least one core faculty member certified in internal medicine by the ABIM or AOBIM and/or certified in pediatrics by the ABP or AOBP for every eight residents in the program. (Core)	2.11.b.	In addition to the program director, the member certified in internal medicine certified in pediatrics by the ABP or A program. (Core)

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

ate a strong interest in the education sufficient time to the educational y and teaching responsibilities.

r and maintain an educational ing residents. (Core)

participate in organized clinical s, and conferences. (Core)

culty development designed to ally: (Core)

tail)

ng health inequities, and patient

sidents' well-being; and, (Detail) ctice-based learning and

opriate qualifications in their field appointments. (Core)

opriate qualifications in their field appointments. (Core)

have current certification in the of Internal Medicine (ABIM), the or the American Osteopathic Board e American Osteopathic Board of lifications judged acceptable to the

a significant role in the education must devote a significant portion of ation and/or administration, and tivities, teach, evaluate, and provide (Core)

lete the annual ACGME Faculty

here must be at least one core faculty e by the ABIM or AOBIM and/or AOBP for every eight residents in the

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
II.B.4.c)	Among the program director and the required number of medicine-pediatrics core faculty members, at least 50 percent of the individuals must be currently certified in internal medicine by the ABIM or AOBIM and at least 50 percent of the individuals must be currently certified in pediatrics by the ABP or AOBP. (Core)	2.11.c.	Among the program director and the repediatrics core faculty members, at least currently certified in internal medic least 50 percent of the individuals muby the ABP or AOBP. (Core)
II.C.	Program Coordinator	2.12.	Program Coordinator There must be a program coordina
II.C.1.	There must be a program coordinator. (Core)	2.12.	Program Coordinator There must be a program coordina
II.C.2.	The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)	2.12.a.	The program coordinator must be a support adequate for administratio size and configuration. (Core)
	At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on the program size as follows: (Core) Number of Approved Resident Positions:<7   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: n/a Number of Approved Resident Positions:7-10   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: n/a Number of Approved Resident Positions:710   Minimum FTE Required for Administration of the Program: 0.2 Number of Approved Resident Positions:11-15   Minimum FTE Required for Administration of the Program: 0.2		At a minimum, the program coordinate dedicated time and support specified program. Additional administrative sup program size as follows: (Core) Number of Approved Resident Positic Coordinator Support: 0.5   Additional Administration of the Program: n/a Number of Approved Resident Positic Coordinator Support: 0.5   Additional Administration of the Program: 0.2 Number of Approved Resident Positic for Coordinator Support: 0.5   Additional Administration of the Program: 0.3
	<ul> <li>Number of Approved Resident Positions:16-20   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 0.4</li> <li>Number of Approved Resident Positions:21-25   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 0.5</li> <li>Number of Approved Resident Positions:26-30   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for</li> <li>Number of Approved Resident Positions:26-30   Minimum FTE Required for</li> <li>Coordinator Support: 0.5   Additional Aggregate FTE Required for</li> </ul>		Number of Approved Resident Positic for Coordinator Support: 0.5   Additio Administration of the Program: 0.4 Number of Approved Resident Positic for Coordinator Support: 0.5   Additio Administration of the Program: 0.5 Number of Approved Resident Positic for Coordinator Support: 0.5   Additio
II.C.2.a)	Administration of the Program: 0.6	2.12.b.	Administration of the Program: 0.6

e required number of medicineleast 50 percent of the individuals must icine by the ABIM or AOBIM and at nust be currently certified in pediatrics

# ator. (Core)

# ator. (Core)

e provided with dedicated time and ion of the program based upon its

ator must be provided with the ed below for administration of the support must be provided based on the

tions:<7 | Minimum FTE Required for al Aggregate FTE Required for

tions:7-10 | Minimum FTE Required for al Aggregate FTE Required for

tions:11-15 | Minimum FTE Required ional Aggregate FTE Required for

tions:16-20 | Minimum FTE Required ional Aggregate FTE Required for

tions:21-25 | Minimum FTE Required ional Aggregate FTE Required for

tions:26-30 | Minimum FTE Required ional Aggregate FTE Required for

Roman Numeral Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requirement Language
	Number of Approved Resident Positions:31-35   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 0.7		Number of Approved Resident Positions:31-35   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 0.7
	Number of Approved Resident Positions:36-40   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 0.8		Number of Approved Resident Positions:36-40   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 0.8
	Number of Approved Resident Positions:41-45   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 0.9		Number of Approved Resident Positions:41-45   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 0.9
	Number of Approved Resident Positions:46-50   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.0		Number of Approved Resident Positions:46-50   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.0
	Number of Approved Resident Positions:51-55   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.1		Number of Approved Resident Positions:51-55   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.1
	Number of Approved Resident Positions:56-60   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.2	2.12.b (Continued)	Number of Approved Resident Positions:56-60   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.2
	Number of Approved Resident Positions:61-65   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.3		Number of Approved Resident Positions:61-65   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.3
II.C.2.a) - (Continued)	Number of Approved Resident Positions:> 65   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.4	2.12.b (Continued)	Number of Approved Resident Positions:> 65   Minimum FTE Required for Coordinator Support: 0.5   Additional Aggregate FTE Required for Administration of the Program: 1.4
	Other Program Personnel		Other Brogram Baraannal
II.D.	The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)	2.13.	Other Program Personnel The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.D.1.	The program must provide support for other support personnel required for operation of the program. (Core)	2.13.a.	The program must provide support for other support personnel required for operation of the program. (Core)
III.	Resident Appointments	Section 3	Section 3: Resident Appointments
III.A.	Eligibility Requirements	3.2.	Eligibility Requirements An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)
III.A.1.	An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)	3.2.	Eligibility Requirements An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)
III.A.1.a)	graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)	3.2.a.	graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)
III.A.1.b)	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)	3.2.b.	<ul> <li>graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)</li> <li>holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)</li> <li>holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)</li> </ul>
III.A.1.b).(1)	holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)	3.2.b.	<ul> <li>graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)</li> <li>holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)</li> <li>holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)</li> </ul>
III.A.1.b).(2)	holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)	3.2.b.	<ul> <li>graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)</li> <li>holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)</li> <li>holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)</li> </ul>

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
III.A.2.	All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)- accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)	3.3.	All prerequisite post-graduate clini entry or transfer into ACGME-accre completed in ACGME-accredited re residency programs, Royal College Canada (RCPSC)-accredited or Co Canada (CFPC)-accredited residen in residency programs with ACGM Advanced Specialty Accreditation.
III.A.2.a)	Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)	3.3.a.	Residency programs must receive of competency in the required clini or ACGME-I Milestones evaluations upon matriculation. (Core)
III.B.	Resident Complement The program director must not appoint more residents than approved by the Review Committee. (Core)	3.4.	Resident Complement The program director must not app by the Review Committee. (Core)
III.C.	Resident Transfers The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)	3.5.	Resident Transfers The program must obtain verification experiences and a summative com evaluation prior to acceptance of a Milestones evaluations upon matrice
III.C.1.	Residents must not enter the combined residency program beyond the beginning of the PGY-2 level. (Core)	3.5.a.	Residents must not enter the combine beginning of the PGY-2 level. (Core)
	Educational Program The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.		Section 4: Educational Program The ACGME accreditation system i excellence and innovation in gradu of the organizational affiliation, size
	The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.		The educational program must sup knowledgeable, skillful physicians
N/	It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician- scientists will have a different curriculum from one focusing on	Section 4	It is recognized programs may place leadership, public health, etc. It is e will reflect the nuanced program-sp graduates; for example, it is expect prepare physician-scientists will he focusing on community boolth
IV. IV.A.	<i>community health.</i> Educational Components The curriculum must contain the following educational components:	4.2.	focusing on community health. Educational Components The curriculum must contain the fo

nical education required for initial credited residency programs must be residency programs, AOA-approved ge of Physicians and Surgeons of college of Family Physicians of ency programs located in Canada, or ME International (ACGME-I) n. (Core)

ve verification of each resident's level inical field using ACGME, CanMEDS, ons from the prior training program

point more residents than approved

## ation of previous educational mpetency-based performance f a transferring resident, and triculation. (Core)

ned residency program beyond the

n is designed to encourage duate medical education regardless ize, or location of the program.

upport the development of is who provide compassionate care.

ace different emphasis on research, s expected that the program aims -specific goals for it and its ected that a program aiming to have a different curriculum from one

following educational components:

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
IV.A.1.	a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)	4.2.a.	mission, the needs of the communi distinctive capabilities of its gradua available to program applicants, res (Core)
IV.A.2.	competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)	4.2.b.	competency-based goals and object experience designed to promote pro autonomous practice. These must be available to residents and faculty m
IV.A.3.	delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)	4.2.c.	delineation of resident responsibilit responsibility for patient managem (Core)
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured didaction
IV.A.4.a)	Residents must be provided with protected time to participate in core didactic activities. (Core)	4.11.	Didactic and Clinical Experiences Residents must be provided with pr didactic activities. (Core)
IV.A.5.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)	4.2.e.	formal educational activities that pr goals, tools, and techniques. (Core)
IV.B.	ACGME Competencies	[None]	ACGME Competencies The Competencies provide a concer required domains for a trusted physicians, and though the specifics a physicians, although the specifics a specialty. The developmental traject Competencies are articulated throut specialty.
	The program must integrate the following ACGME Competencies into the		The program must integrate all ACC
IV.B.1.	curriculum:         Professionalism         Residents must demonstrate a commitment to professionalism and an	[None]	curriculum. ACGME Competencies – Profession Residents must demonstrate a com an adherence to ethical principles.
IV.B.1.a)	adherence to ethical principles. (Core)	4.3.	Residents must demonstrate comp
			ACGME Competencies – Profession Residents must demonstrate a com an adherence to ethical principles.
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	Residents must demonstrate comp
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)	4.3.a.	compassion, integrity, and respect
IV.B.1.a).(1).(b)	responsiveness to patient needs that supersedes self-interest; (Core)	4.3.b.	responsiveness to patient needs th
IV.B.1.a).(1).(c)	cultural humility; (Core)	4.3.c.	cultural humility; (Core)
IV.B.1.a).(1).(d)	respect for patient privacy and autonomy; (Core)	4.3.d.	respect for patient privacy and auto
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)	4.3.e.	accountability to patients, society, a

nity it serves, and the desired uates, which must be made residents, and faculty members;

ectives for each educational progress on a trajectory to t be distributed, reviewed, and members; (Core)

ilities for patient care, progressive ment, and graded supervision;

tic activities; and, (Core)

protected time to participate in core

promote patient safety-related re)

ceptual framework describing the hysician to enter autonomous e core to the practice of all s are further defined by each ectories in each of the bugh the Milestones for each

CGME Competencies into the

onalism

ommitment to professionalism and s. (Core)

petence in:

onalism ommitment to professionalism and s. (Core)

petence in:

ct for others; (Core)

that supersedes self-interest; (Core)

ıtonomy; (Core)

, and the profession; (Core)

Roman Numeral Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requiremen
			respect and responsiveness to dive
	respect and responsiveness to diverse patient populations, including but		but not limited to diversity in gende
	not limited to diversity in gender, age, culture, race, religion, disabilities,		disabilities, national origin, socioe
IV.B.1.a).(1).(f)	national origin, socioeconomic status, and sexual orientation; (Core)	4.3.f.	orientation; (Core)
	ability to recognize and develop a plan for one's own personal and		ability to recognize and develop a
IV.B.1.a).(1).(g)	professional well-being; and, (Core)	4.3.g.	professional well-being; and, (Core
	appropriately disclosing and addressing conflict or duality of interest.		appropriately disclosing and addre
IV.B.1.a).(1).(h)	(Core)	4.3.h.	(Core)
IV.B.1.b)	Patient Care and Procedural Skills	[None]	
IV.B.1.b).(1)	Residents must be able to provide patient care that is patient- and family- centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)	4.4.	ACGME Competencies – Patient Ca Residents must be able to provide family-centered, compassionate, ec for the treatment of health problem (Core)
IV.B.1.b).(1).(a)	Residents must demonstrate the ability to:	4.4.a.	Residents must demonstrate the abilit
IV.B.1.b).(1).(a).(i)	manage patients in a variety of roles within a health system with progressive responsibility, to include serving as the direct provider, the leader or member of a multi-disciplinary team of providers, a consultant to other physicians, and a teacher to the patient, family, and other physicians; (Core)	4.4.a.1.	manage patients in a variety of roles v progressive responsibility, to include s leader or member of a multi-disciplina other physicians, and a teacher to the (Core)
IV.B.1.b).(1).(a).(ii)	manage patients in the prevention, counseling, detection, and diagnosis and treatment of gender-specific diseases; (Core)	4.4.a.2.	manage patients in the prevention, co and treatment of gender-specific dise
IV.B.1.b).(1).(a).(iii)	manage patients in a variety of health care settings, to include the inpatient ward, the critical care units, the emergency setting, and the ambulatory setting; (Core)	4.4.a.3.	manage patients in a variety of health ward, the critical care units, the emerg setting; (Core)
IV.B.1.b).(1).(a).(iv)	manage patients across the spectrum of clinical disorders seen in the practice of general internal medicine and pediatrics in both inpatient and ambulatory settings; (Core)	4.4.a.4.	manage patients across the spectrum practice of general internal medicine a ambulatory settings; (Core)
	manage a sufficient number of undifferentiated acutely and severely ill patients;		manage a sufficient number of undiffe
IV.B.1.b).(1).(a).(v)	(Core)	4.4.a.5.	patients; (Core)
IV.B.1.b).(1).(a).(vi)	gather essential and accurate information about the patient; (Core)	4.4.a.6.	gather essential and accurate informa
	organize and prioritize responsibilities to provide patient care that is safe,		organize and prioritize responsibilities
IV.B.1.b).(1).(a).(vii)	effective, and efficient; (Core)	4.4.a.7.	effective, and efficient; (Core)
IV.B.1.b).(1).(a).(viii)	provide transfer of care that ensures seamless transitions; (Core)	4.4.a.8.	provide transfer of care that ensures s
IV.B.1.b).(1).(a).(ix)	interview patients and families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family unit correlates of disease; (Core)	4.4.a.9.	interview patients and families about t condition for which they seek care, wi psychosocial, environmental, and fam
IV.B.1.b).(1).(a).(x)	perform complete and accurate physical examinations; (Core)	4.4.a.10.	perform complete and accurate physic
IV.B.1.b).(1).(a).(xi)	make informed diagnostic and therapeutic decisions that result in optimal clinical judgment; (Core)	4.4.a.11.	make informed diagnostic and therapo clinical judgment; (Core)
IV.B.1.b).(1).(a).(xii)	develop and carry-out management plans; (Core)	4.4.a.12.	develop and carry-out management p
IV.B.1.b).(1).(a).(xiii)	provide effective health maintenance and anticipatory guidance; (Core)	4.4.a.13.	provide effective health maintenance
IV.B.1.b).(1).(a).(xiv)	provide appropriate role modeling; and, (Core)	4.4.a.14.	provide appropriate role modeling; an
IV.B.1.b).(1).(a).(xv)	provide appropriate supervision. (Core)	4.4.a.15.	provide appropriate supervision. (Core

verse patient populations, including der, age, culture, race, religion, economic status, and sexual

plan for one's own personal and re)

ressing conflict or duality of interest.

# Care and Procedural Skills (Part A)

e patient care that is patient- and equitable, appropriate, and effective ms and the promotion of health.

#### ility to:

within a health system with e serving as the direct provider, the nary team of providers, a consultant to ne patient, family, and other physicians;

counseling, detection, and diagnosis eases; (Core)

th care settings, to include the inpatient ergency setting, and the ambulatory

m of clinical disorders seen in the and pediatrics in both inpatient and

ferentiated acutely and severely ill

nation about the patient; (Core) es to provide patient care that is safe,

s seamless transitions; (Core)

t the particulars of the medical with specific attention to behavioral, mily unit correlates of disease; (Core) sical examinations; (Core)

peutic decisions that result in optimal

plans; (Core)

e and anticipatory guidance; (Core) and, (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
IV.B.1.b).(2)	Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)	4.5.	ACGME Competencies – Patient Ca Residents must be able to perform surgical procedures considered ess (Core)
IV.B.1.b).(2).(a)	Residents must demonstrate the ability to manage patients using the laboratory and imaging techniques appropriately; (Core)	4.5.a.	Residents must demonstrate the abilit laboratory and imaging techniques ap
IV.B.1.b).(2).(b)	Residents must treat their patient's conditions with practices that are safe, scientifically based, effective, efficient, timely, and cost effective; (Core)	4.5.b.	Residents must treat their patient's co scientifically based, effective, efficient
IV.B.1.b).(2).(c)	Residents must be able to competently perform procedures used by an internist and pediatrician in general practice, including being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of applicable results; (Core)	4.5.c.	Residents must be able to competentl internist and pediatrician in general pr describe the steps in the procedure, ir complications, pain management, pos of applicable results. (Core)
IV.B.1.b).(2).(d)	Residents must demonstrate procedural competence by performing the following procedures on pediatric patients; and: (Core)	4.5.d.	Residents must demonstrate procedures on pediatric patients and the procedures on pediatric patients of the procedures on pediatric patients of the procedures of the procedur
IV.B.1.b).(2).(d).(i)	bag-mask ventilation; (Core)	4.5.d.1.	bag-mask ventilation; (Core)
IV.B.1.b).(2).(d).(ii)	bladder catheterization; (Core)	4.5.d.2.	bladder catheterization; (Core)
IV.B.1.b).(2).(d).(iii)	immunizations; (Core)	4.5.d.3.	immunizations; (Core)
IV.B.1.b).(2).(d).(iv)	incision and drainage of abscess; (Core)	4.5.d.4.	incision and drainage of abscess; (Co
IV.B.1.b).(2).(d).(v)	lumbar puncture; (Core)	4.5.d.5.	lumbar puncture; (Core)
IV.B.1.b).(2).(d).(vi)	neonatal endotracheal intubation; (Core)	4.5.d.6.	neonatal endotracheal intubation; (Co
IV.B.1.b).(2).(d).(vii)	peripheral intravenous catheter placement; (Core)	4.5.d.7.	peripheral intravenous catheter placer
IV.B.1.b).(2).(d).(viii)	reduction of simple dislocation; (Core)	4.5.d.8.	reduction of simple dislocation; (Core)
IV.B.1.b).(2).(d).(ix)	simple laceration repair; (Core)	4.5.d.9.	simple laceration repair; (Core)
IV.B.1.b).(2).(d).(x)	simple removal of foreign body; (Core)	4.5.d.10.	simple removal of foreign body; (Core
IV.B.1.b).(2).(d).(xi)	temporary splinting of fracture; (Core)	4.5.d.11.	temporary splinting of fracture; (Core)
IV.B.1.b).(2).(d).(xii)	umbilical catheter placement; and, (Core)	4.5.d.12.	umbilical catheter placement; and, (Co
IV.B.1.b).(2).(d).(xiii)	venipuncture. (Core)	4.5.d.13.	venipuncture. (Core)
IV.B.1.b).(2).(e)	Residents must complete training and maintain certification in Pediatric Advanced Life Support, including simulated placement of an intraosseous line, and neonatal resuscitation. (Core)	4.5.e.	Residents must complete training and Advanced Life Support, including simu line, and neonatal resuscitation. (Core
IV.B.1.c)	Medical Knowledge Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)	4.6.	ACGME Competencies – Medical K Residents must demonstrate know biomedical, clinical, epidemiologica including scientific inquiry, as well knowledge to patient care. (Core)
IV.B.1.c).(1)	Residents must demonstrate knowledge of those areas appropriate for an internal medicine and pediatrics specialist, specifically: (Core)	4.6.a.	Residents must demonstrate knowled internal medicine and pediatrics speci
IV.B.1.c).(1).(a)	the broad spectrum of clinical disorders seen in the practices of general internal medicine and pediatrics; and, (Core)	4.6.1.	the broad spectrum of clinical disorder internal medicine and pediatrics; and,

nt Language
Care <mark>and</mark> Procedural Skills <mark>(Part B)</mark> n all medical, diagnostic, and ssential for the area of practice.
lity to manage patients using the ppropriately. (Core)
conditions with practices that are safe, nt, timely, and cost effective. (Core)
ntly perform procedures used by an practice, including being able to indications, contraindications, pst-procedure care, and interpretation
ural competence by performing the tients: (Core)
core)
core)
ement; (Core) e)
re)
e)
Core)
,
nd maintain certification in Pediatric nulated placement of an intraosseous re)
Knowledge wledge of established and evolving cal, and social-behavioral sciences, II as the application of this
edge of those areas appropriate for an cialist, specifically: (Core)
ers seen in the practices of general

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
	the core content of general internal medicine and pediatrics, including the		the core content of general internal m
	subspecialties and relevant specialties outside of internal medicine and		subspecialties and relevant specialties
IV.B.1.c).(1).(b)	pediatrics. (Core)	4.6.2.	pediatrics. (Core)
IV.B.1.c).(2)	Residents must demonstrate sufficient knowledge:	4.6.b.	Residents must demonstrate sufficien
	to evaluate patients with an undiagnosed and undifferentiated presentation;		to evaluate patients with an undiagnos
IV.B.1.c).(2).(a)	(Core)	4.6.b.1.	presentation; (Core)
IV.B.1.c).(2).(b)	to treat medical conditions common to children and adults; (Core)	4.6.b.2.	to treat medical conditions common to
IV.B.1.c).(2).(c)	to provide preventive care; (Core)	4.6.b.3.	to provide preventive care; (Core)
IV.B.1.c).(2).(d)	to interpret clinical tests and images commonly used by general internists and pediatricians; (Core)	4.6.b.4.	to interpret clinical tests and images c and pediatricians; (Core)
IV.B.1.c).(2).(e)	to recognize and provide initial management of emergency medical problems; (Core)	4.6.b.5.	to recognize and provide initial manag problems; (Core)
IV.B.1.c).(2).(f)	of pharmacotherapy; and, (Core)	4.6.b.6.	of pharmacotherapy; and, (Core)
IV.B.1.c).(2).(g)	to appropriately use and perform diagnostic and therapeutic procedures. (Core)	4.6.b.7.	to appropriately use and perform diag (Core)
IV.B.1.c).(3)	Residents must demonstrate sufficient knowledge of the basic and clinically supportive sciences appropriate to internal medicine and pediatrics. (Core)	4.6.c.	Residents must demonstrate sufficien clinically supportive sciences appropri pediatrics. (Core)
IV.B.1.c).(4)	Residents must demonstrate an understanding of the indications and contraindications for, and complications of the following pediatric procedures: (Core)	4.6.d.	Residents must demonstrate an unde contraindications for, and complication procedures: (Core)
IV.B.1.c).(4).(a)	arterial line placement; (Core)	4.6.d.1.	arterial line placement; (Core)
IV.B.1.c).(4).(b)	arterial puncture; (Core)	4.6.d.2.	arterial puncture; (Core)
IV.B.1.c).(4).(c)	chest tube placement; (Core)	4.6.d.3.	chest tube placement; (Core)
IV.B.1.c).(4).(d)	circumcision; (Core)	4.6.d.4.	circumcision; (Core)
IV.B.1.c).(4).(e)	endotracheal intubation of non-neonates; and, (Core)	4.6.d.5.	endotracheal intubation of non-neonal
IV.B.1.c).(4).(f)	thoracentesis. (Core)	4.6.d.6.	thoracentesis. (Core)
IV.B.1.c).(5)	Residents should receive real and/or simulated training when these procedures are important for a resident's post-residency career. (Detail)	4.6.e.	Residents should receive real and/or s procedures are important for a resider
IV.B.1.d)	Practice-based Learning and Improvement Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning; (Core)	4.7.	ACGME Competencies – Practice-E Residents must demonstrate the at their care of patients, to appraise a and to continuously improve patien evaluation and lifelong learning. (C
IV.B.1.d).(1)	Residents must demonstrate competence in:	[None]	
IV.B.1.d).(1).(a)	identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)	4.7.a.	Residents must demonstrate comp deficiencies, and limits in one's kno
IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)	4.7.b.	Residents must demonstrate comp improvement goals. (Core)
IV.B.1.d).(1).(c)	identifying and performing appropriate learning activities; (Core)	4.7.c.	Residents must demonstrate comp performing appropriate learning ac

medicine and pediatrics, including the ies outside of internal medicine and

ent knowledge:

losed and undifferentiated

to children and adults; (Core)

commonly used by general internists

agement of emergency medical

agnostic and therapeutic procedures.

ent knowledge of the basic and priate to internal medicine and

derstanding of the indications and ions of the following pediatric

nates; and, (Core)

r simulated training when these ent's post-residency career. (Detail)

-Based Learning and Improvement ability to investigate and evaluate and assimilate scientific evidence, ent care based on constant self-Core)

npetence in identifying strengths, nowledge and expertise. (Core) npetence in setting learning and

npetence in identifying and activities. (Core)

Roman Numeral Requirement Number	Poquiroment Lenguage	Reformatted Requirement Number	Dominant
number	Requirement Language	Requirement Number	Requiremen
IV.B.1.d).(1).(d)	systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)	4.7.d.	Residents must demonstrate comp practice using quality improvemen aimed at reducing health care disp with the goal of practice improvem
IV.B.1.d).(1).(e)	incorporating feedback and formative evaluation into daily practice; and, (Core)	4.7.e.	Residents must demonstrate comp and formative evaluation into daily
IV.B.1.d).(1).(f)	locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)	4.7.f.	Residents must demonstrate comp assimilating evidence from scientif health problems. (Core)
IV.B.1.d).(1).(g)	being an effective teacher; and, (Core)	4.7.g.	Residents must demonstrate compete (Core)
IV.B.1.d).(1).(h)	taking primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and experience- specific goals and objectives and attendance at conferences. (Core)	4.7.h.	Residents must demonstrate competer for lifelong learning to improve knowler through familiarity with general and ex objectives and attendance at conferer
IV.B.1.e)	Interpersonal and Communication Skills Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)	4.8.	ACGME Competencies – Interperso Residents must demonstrate interp that result in the effective exchange with patients, their families, and he
IV.B.1.e).(1)	Residents must demonstrate competence in:	[None]	
IV.B.1.e).(1).(a)	communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)	4.8.a.	Residents must demonstrate comp effectively with patients and patient a broad range of socioeconomic cir backgrounds, and language capabi interpretive services as required to patient. <sup>(Core)</sup>
IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; (Core)	4.8.b.	Residents must demonstrate comp effectively with physicians, other h related agencies. (Core)
IV.B.1.e).(1).(c)	working effectively as a member or leader of a health care team or other professional group; (Core)	4.8.c.	Residents must demonstrate comp member or leader of a health care t (Core)
IV.B.1.e).(1).(d)	educating patients, patients' families, students, other residents, and other health professionals; (Core)	4.8.d.	Residents must demonstrate comp patients' families, students, other re professionals. (Core)
IV.B.1.e).(1).(e)	acting in a consultative role to other physicians and health professionals; (Core)	4.8.e.	Residents must demonstrate comp role to other physicians and health
IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible health care records, if applicable; and, (Core)	4.8.f.	Residents must demonstrate comp comprehensive, timely, and legible (Core)
IV.B.1.e).(1).(g)	demonstrating the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions. (Core)	4.8.h.	Residents must demonstrate the insig and human response to emotion that and manage human interactions. (Cor

npetence in systematically analyzing nt methods, including activities parities, and implementing changes ment. (Core)

petence in incorporating feedback y practice. (Core)

petence in locating, appraising, and tific studies related to their patients'

tence in being an effective teacher.

etence in taking primary responsibility /ledge, skills, and practice performance experience-specific goals and ences. (Core)

sonal and Communication Skills rpersonal and communication skills ge of information and collaboration nealth professionals. (Core)

petence in communicating ents' families, as appropriate, across circumstances, cultural bilities, learning to engage to provide appropriate care to each

petence in communicating health professionals, and health-

petence in working effectively as a team or other professional group.

petence in educating patients, residents, and other health

npetence in acting in a consultative th professionals. (Core)

petence in maintaining le health care records, if applicable.

sight and understanding into emotion at allows one to appropriately develop fore)

Roman Numeral Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requirement
	Residents must learn to communicate with patients and patients' families		Residents must learn to communic
	to partner with them to assess their care goals, including, when		families to partner with them to ass
IV.B.1.e).(2)	appropriate, end-of-life goals. (Core)	4.8.g.	when appropriate, end-of-life goals
	Systems-based Practice		
			ACGME Competencies - Systems-B
	Residents must demonstrate an awareness of and responsiveness to the		Residents must demonstrate an aw
	larger context and system of health care, including the structural and		the larger context and system of he
	social determinants of health, as well as the ability to call effectively on		and social determinants of health, a
IV.B.1.f)	other resources to provide optimal health care. (Core)	4.9.	effectively on other resources to pr
IV.B.1.f).(1)	Residents must demonstrate competence in:	[None]	
			Residents must demonstrate comp
	working effectively in various health care delivery settings and systems		various health care delivery setting
IV.B.1.f).(1).(a)	relevant to their clinical specialty; (Core)	4.9.a.	clinical specialty. <sup>(Core)</sup>
			Residents must demonstrate comp
	coordinating patient care across the health care continuum and beyond as		across the health care continuum a
IV.B.1.f).(1).(b)	relevant to their clinical specialty; (Core)	4.9.b.	clinical specialty. <sup>(Core)</sup>
	advocating for quality patient care and optimal patient care systems;		Residents must demonstrate comp
IV.B.1.f).(1).(c)	(Core)	4.9.c.	patient care and optimal patient car
			Residents must demonstrate comp
_	participating in identifying system errors and implementing potential		identifying system errors and imple
IV.B.1.f).(1).(d)	systems solutions; (Core)	4.9.d.	solutions. (Core)
			Residents must demonstrate comp
	incorporating considerations of value, equity, cost awareness, delivery		considerations of value, equity, cos
	and payment, and risk-benefit analysis in patient and/or population-based		payment, and risk-benefit analysis
IV.B.1.f).(1).(e)	care as appropriate; (Core)	4.9.e.	care as appropriate. (Core)
			Residents must demonstrate comp
	understanding health care finances and its impact on individual patients'	105	care finances and its impact on ind
IV.B.1.f).(1).(f)	health decisions; and, (Core)	4.9.f.	(Core)
			Residents must demonstrate comp
	using tools and techniques that promote patient safety and disclosure of		techniques that promote patient sa
IV.B.1.f).(1).(g)	patient safety events (real or simulated). (Detail)	4.9.g.	safety events (real or simulated). <sup>(De</sup>
			Residents must demonstrate compete
	working in teams and effectively transmitting necessary clinical information to		effectively transmitting necessary clini
(1/D 4 f) (4) (b)	ensure safe and proper care of patients including the transition of care between	4.0.5	proper care of patients including the tr
IV.B.1.f).(1).(h)	settings; and, (Core)	4.9.i.	(Core)
	advocating for the promotion of health and the provention of disease and injury		Posidonte must domonstrato compote
IV.B.1.f).(1).(i)	advocating for the promotion of health and the prevention of disease and injury in populations. (Core)	4.9.j.	Residents must demonstrate compete of health and the prevention of diseas
		т.v.j.	· · ·
	Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals,		Residents must learn to advocate for system to achieve the patient's and
IV.B.1.f).(2)	including, when appropriate, end-of-life goals. (Core)	4.9.h.	including, when appropriate, end-or
		T.V.II.	including, when appropriate, end-o

icate with patients and patients' ssess their care goals, including, Is. (Core)

## -Based Practice

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

npetence in working effectively in ngs and systems relevant to their

petence in coordinating patient care and beyond as relevant to their

petence in advocating for quality are systems. (Core)

petence in participating in plementing potential systems

petence in incorporating ost awareness, delivery and s in patient and/or population-based

npetence in understanding health ndividual patients' health decisions.

petence in using tools and safety and disclosure of patient (Detail)

etence in working in teams and inical information to ensure safe and transition of care between settings.

etence in advocating for the promotion ase and injury in populations. (Core)

e for patients within the health care nd patient's family's care goals, -of-life goals. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
			Curriculum Organization and Resid
			4.10. Curriculum Structure The curriculum must be structured experiences, the length of the experiences continuity. These educational experient blend of supervised patient care rest and didactic educational events. (C
			4.11. Didactic and Clinical Experien Residents must be provided with pr didactic activities. (Core)
IV.C.	Curriculum Organization and Resident Experiences	4.10 4.12.	4.12. Pain Management The program must provide instructi management if applicable for the sp the signs of substance use disorder
IV.C.1.	The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)	4.10.	Curriculum Structure The curriculum must be structured experiences, the length of the experiences, the length of the experiences, the seducational experient care rest blend of supervised patient care rest and didactic educational events. (C
IV.C.1.a)	Programs should develop models and schedules for ambulatory training that minimize conflicting inpatient and outpatient responsibilities. (Detail)	4.10.a.	Programs should develop models and that minimize conflicting inpatient and
IV.C.2.	The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)	4.12.	Pain Management The program must provide instructi management if applicable for the sp the signs of substance use disorde
IV.C.3.	The core curriculum must include a didactic program based upon the core knowledge content of internal medicine and pediatrics to ensure each resident acquires the knowledge, skills, and attitudes needed for the practice of medicine and pediatrics. (Core)	4.11.a.	The core curriculum must include a did knowledge content of internal medicine resident acquires the knowledge, skills practice of medicine and pediatrics. (C
IV.C.3.a)	The program must afford each resident an opportunity to review all of the core curriculum topics. (Core)	4.11.a.1.	The program must afford each resider core curriculum topics. (Core)
IV.C.3.a).(1)	The didactic program should include lectures, web-based content, pod casts, etc. (Detail)	4.11.a.2.	The didactic program should include le casts, etc. (Detail)
IV.C.3.b)	Residents should have the opportunity to participate in morning report, grand rounds, journal club, and morbidity and mortality (or quality improvement) conferences that also involve faculty. (Detail)	4.11.a.3.	Residents should have the opportunity grand rounds, journal club, and morbic improvement) conferences that also in
IV.C.3.c)	The program should document monthly meetings for educational activities with internal medicine-pediatrics residents, such as jointly-sponsored journal clubs, clinic conferences, occasional combined grand rounds, conferences on medical ethics program administration and research. (Detail)	4.11.a.4.	The program should document monthl with internal medicine-pediatrics reside journal clubs, clinic conferences, occa conferences on medical ethics program (Detail)

nt Language
ident Experiences
d to optimize resident educational periences, and the supervisory eriences include an appropriate esponsibilities, clinical teaching, Core)
ences protected time to participate in core
ction and experience in pain specialty, including recognition of ler. (Core)
d to optimize resident educational periences, and the supervisory eriences include an appropriate esponsibilities, clinical teaching, Core)
nd schedules for ambulatory training d outpatient responsibilities. (Detail)
ction and experience in pain specialty, including recognition of ler. (Core)
didactic program based upon the core ine and pediatrics to ensure each ills, and attitudes needed for the (Core)
ent an opportunity to review all of the
lectures, web-based content, pod
ity to participate in morning report, pidity and mortality (or quality involve faculty. (Detail)
thly meetings for educational activities idents, such as jointly-sponsored casional combined grand rounds, ram administration and research.

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
IV.C.3.d)	The program should provide opportunities for residents to have peer-peer and peer-faculty interaction. (Detail)	4.11.a.5.	The program should provide opportun and peer-faculty interaction. (Detail)
IV.C.4.	Patient-based teaching must include direct interaction between the resident and the attending physician at the patient's bedside, in consultative services or in clinic settings with discussion of pathophysiology and use of up-to-date diagnostic and therapeutic evidence. (Core)	4.11.b.	Patient-based teaching must include or resident and the attending physician a consultative services or in clinic setting pathophysiology and use of up-to-date evidence. (Core)
IV.C.5.	Curriculum	4.11.c.	Curriculum The majority of educational experience internal medicine-pediatrics curriculum educational experiences and training to the categorical internal medicine progra Internal Medicine and as part of the categories and the categories and the categories and the categories of the categories and
IV.C.5.a)	The majority of educational experiences that constitute the combined internal medicine-pediatrics curriculum must be derived from the educational experiences and training that have been accredited as part of the categorical internal medicine program by the Review Committee for Internal Medicine and as part of the categorical pediatrics program by the Review Committee for Pediatrics. (Core)	4.11.c.	Curriculum The majority of educational experience internal medicine-pediatrics curriculun educational experiences and training t the categorical internal medicine prog Internal Medicine and as part of the ca Review Committee for Pediatrics. (Co
IV.C.5.b)	The curriculum must provide a cohesive planned educational experience, and not simply be a series of rotations between the two specialties. (Core)	4.11.c.1.	The curriculum must provide a cohesi and not simply be a series of rotations
IV.C.5.c)	For each required rotation (four-week or one-month block or longitudinal experience), a faculty member must be responsible for curriculum development, and ensuring orientation, supervision, teaching, and timely feedback and evaluation. (Core)	4.11.c.2.	For each required rotation (four-week experience), a faculty member must b development, and ensuring orientatior feedback and evaluation. (Core)
IV.C.5.d)	Residents must have graded responsibility for patient care and teaching. (Core)	4.11.c.3.	Residents must have graded responsi (Core)
IV.C.5.e)	There must be 24 months of training in each specialty. (Core)	4.11.c.4.	There must be 24 months of training in
IV.C.5.e).(1)	Twenty-two months of training must be in clinical rotations and other educational experiences. (Core)	4.11.c.4.a.	Twenty-two months of training must be educational experiences. (Core)
IV.C.5.f)	Night assignments should have formal goals, objectives, and a specific evaluation component. (Core)	4.11.c.5.	Night assignments should have forma evaluation component. (Core)
IV.C.5.g)	Off-site elective experiences should not exceed two months in either specialty (no more than two months in internal medicine, and no more than two months in pediatrics) during the four years of training. (Detail)	4.11.c.6.	Off-site elective experiences should ne specialty (no more than two months in two months in pediatrics) during the fo
IV.C.5.h)	Continuous assignments to one specialty or the other should be for periods of at least one rotation and not more than six rotations. (Detail)	4.11.c.7.	Continuous assignments to one specia of at least one rotation and not more t
IV.C.5.i)	In order to provide a breadth of exposure, unnecessary duplication of educational experiences should be avoided. (Detail)	4.11.c.8.	In order to provide a breadth of expos educational experiences should be av
IV.C.6.	Continuity Clinics	4.11.d.	Continuity Clinics The longitudinal continuity experience continuous, long-term therapeutic rela medicine and pediatric patients. (Core

unities for residents to have peer-peer

e direct interaction between the n at the patient's bedside, in ings with discussion of ate diagnostic and therapeutic

nces that constitute the combined um must be derived from the g that have been accredited as part of ogram by the Review Committee for categorical pediatrics program by the Core)

nces that constitute the combined um must be derived from the g that have been accredited as part of ogram by the Review Committee for categorical pediatrics program by the Core)

sive planned educational experience, ns between the two specialties. (Core)

ek or one-month block or longitudinal be responsible for curriculum on, supervision, teaching, and timely

nsibility for patient care and teaching.

y in each specialty. (Core) be in clinical rotations and other

nal goals, objectives, and a specific

not exceed two months in either in internal medicine, and no more than four years of training. (Detail)

cialty or the other should be for periods than six rotations. (Detail)

osure, unnecessary duplication of avoided. (Detail)

ce must allow residents to develop a elationship with a panel of general pre)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
			Continuity Clinics
	The longitudinal continuity experience must allow residents to develop a		The longitudinal continuity experience
	continuous, long-term therapeutic relationship with a panel of general medicine		continuous, long-term therapeutic rela
IV.C.6.a)	and pediatric patients. (Core)	4.11.d.	medicine and pediatric patients. (Core
IV.C.6.b)	The continuity clinic experience must ensure a minimum of 36 half-day sessions per year of a longitudinal outpatient experience. (Core)	4.11.d.1.	The continuity clinic experience must sessions per year of a longitudinal out
10.0.0)		4.11.0.1.	The sessions must be scheduled over
IV.C.6.b).(1)	The sessions must be scheduled over a minimum of 26 weeks per year. (Core)	4.11.d.1.a.	(Core)
, , , ,	Continuity clinic experience should be obtained either by a combined internal		Continuity clinic experience should be
	medicine-pediatrics continuity clinic or by alternating internal medicine and		internal medicine-pediatrics continuity
IV.C.6.b).(2)	pediatrics continuity clinics. (Detail)	4.11.d.1.b.	medicine and pediatrics continuity clin
IV.C.6.b).(3)	Each resident's longitudinal continuity experience:	[None]	
	should include the resident serving as the primary physician in a medical home		Each resident should serve as the prir
	model for a panel of patients, with responsibility for chronic disease		model for a panel of patients, with res
	management, management of acute health problems, and preventive health		management, management of acute h
IV.C.6.b).(3).(a)	care for their patients; (Detail)	4.11.d.2.	health care for their patients. (Detail)
	should include evaluation of performance data for each resident's continuity		Evaluation of performance data should
IV.C.6.b).(3).(b)	panel of patients relating to both chronic disease management and preventive health care; (Detail)	4.11.d.3.	continuity panel of patients relating to and preventive health care. (Detail)
11.0.0.0).(0).(0)	should include faculty guidance for developing a data-based action plan that is	1.11.0.0.	Faculty guidance should be provided f
IV.C.6.b).(3).(c)	evaluated at least twice a year; (Detail)	4.11.d.4.	plan that is evaluated at least twice a
,,,,,,,	should include resident participation in coordination of care across health care		Residents should participate in coordi
IV.C.6.b).(3).(d)	settings; (Detail)	4.11.d.5.	settings. (Detail)
	Residents should be available to participate in the management of their		Residents should be available to partic
IV.C.6.b).(3).(d).(i)	continuity panel of patients between outpatient visits. (Detail)	4.11.d.5.a.	continuity panel of patients between o
	There should be systems of care to provide coverage of urgent problems when		There should be systems of care to pr
IV.C.6.b).(3).(d).(ii)	a resident is not readily available. (Detail)	4.11.d.5.b.	when a resident is not readily available
			There must be supervision by faculty
V(O, C, h)(2)(c)	must include supervision by faculty who develop a longitudinal relationship with		relationship with residents throughout
IV.C.6.b).(3).(e)	residents throughout the duration of their continuity experience; (Core)	4.11.d.6.	experience. (Core)
IV.C.6.b).(3).(f)	should maintain a ratio of residents or other learners to faculty preceptors not to exceed 4:1; and, (Detail)	4.11.d.7.	A ratio of residents or other learners to exceed 4:1. (Detail)
IV.C.6.b).(3).(g)	must have sufficient supervision and teaching. (Core)	4.11.d.8.	Residents must have sufficient superv
TV:0.0.0).(0).(g)	Faculty should not have other patient care duties while supervising more than	4.11.0.0.	Faculty should not have other patient
IV.C.6.b).(3).(g).(i)	two residents or other learners. (Detail)	4.11.d.8.a.	than two residents or other learners. (I
	Other faculty responsibilities should not detract from the supervision and	-	Other faculty responsibilities should no
IV.C.6.b).(3).(g).(ii)	teaching of residents. (Detail)	4.11.d.8.b.	teaching of residents. (Detail)
	Faculty should have expertise in primary care and the principles of the medical		Faculty should have expertise in prima
IV.C.6.b).(3).(g).(iii)	home. (Detail)	4.11.d.8.c.	medical home. (Detail)
	There must be an adequate volume of patients to ensure exposure to the		There must be an adequate volume of
	spectrum of normal development at all age levels, as well as the longitudinal		spectrum of normal development at al
	management of children and adults with special health care needs and chronic		longitudinal management of children a
IV.C.6.b).(4)	conditions. (Core)	4.11.d.9.	needs and chronic conditions. (Core)
			There must be an even distribution of
N/C 6 h (5)	There must be an even distribution of pediatric and adult patients, whether the	4.11.d.10.	the experience occurs in combined or
IV.C.6.b).(5)	experience occurs in combined or alternating separate clinic settings. (Core)	4. I I.U. IV.	(Core)

ce must allow residents to develop a lationship with a panel of general re)

t ensure a minimum of 36 half-day utpatient experience. (Core)

er a minimum of 26 weeks per year.

be obtained either by a combined ity clinic or by alternating internal linics. (Detail)

rimary physician in a medical home esponsibility for chronic disease e health problems, and preventive )

uld be provided for each resident's to both chronic disease management

d for developing a data-based action a year. (Detail)

dination of care across health care

ticipate in the management of their outpatient visits. (Detail)

provide coverage of urgent problems ble. (Detail)

y who develop a longitudinal ut the duration of their continuity

to faculty preceptors should not

rvision and teaching. (Core)

nt care duties while supervising more (Detail)

not detract from the supervision and

mary care and the principles of the

of patients to ensure exposure to the all age levels, as well as the and adults with special health care )

of pediatric and adult patients, whether or alternating separate clinic settings.

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Number		Requirement Number	
IV.C.6.b).(5).(a)	Residents should see a minimum of 54 adult and a minimum of 54 pediatric patient visits in the PGY-1. (Detail)	4.11.d.10.a.	Residents should see a minimum of 54 adult and a minimum of 54 pediatric patient visits in the PGY-1. (Detail)
IV.C.6.b).(5).(b)	Residents should see a minimum of 72 adult and a minimum of 72 pediatric patient visits in the PGY-2. (Detail)	4.11.d.10.b.	Residents should see a minimum of 72 adult and a minimum of 72 pediatric patient visits in the PGY-2. (Detail)
IV.C.6.b).(5).(c)	Residents should see a minimum of 90 adult and a minimum of 90 pediatric patient visits in the PGY-3. (Detail)	4.11.d.10.c.	Residents should see a minimum of 90 adult and a minimum of 90 pediatric patient visits in the PGY-3. (Detail)
IV.C.6.b).(5).(d)	Residents should see a minimum of 90 adult and a minimum of 90 pediatric patient visits in the PGY-4. (Detail)	4.11.d.10.d.	Residents should see a minimum of 90 adult and a minimum of 90 pediatric patient visits in the PGY-4. (Detail)
IV.C.6.b).(6)	Programs must not be structured to provide sequential continuity experiences, (e.g., 24 months of internal medicine followed by 24 months of pediatrics). (Core)	4.11.d.11.	Programs must not be structured to provide sequential continuity experiences, (e.g., 24 months of internal medicine followed by 24 months of pediatrics). (Core)
IV.C.6.b).(7)	Residents should follow their continuity patients during the course of a hospitalization. (Detail)	4.11.d.12.	Residents should follow their continuity patients during the course of a hospitalization. (Detail)
IV.C.6.b).(8)	PGY-4 residents should continue this experience at the same clinical site or, if appropriate for an individual resident's career goals, sessions in the final year may take place in a longitudinal subspecialty clinic or alternate primary care site. (Detail)	4.11.d.13.	PGY-4 residents should continue this experience at the same clinical site or, if appropriate for an individual resident's career goals, sessions in the final year may take place in a longitudinal subspecialty clinic or alternate primary care site. (Detail)
IV.C.7.	Intensive Care	4.11.e.	Intensive Care The total required critical care experience must not exceed eight months, and must include at least three months in pediatrics and at least two months in internal medicine. (Core)
IV.C.7.a)	The total required critical care experience must not exceed eight months, and must include at least three months in pediatrics and at least two months in internal medicine. (Core)	4.11.e.	Intensive Care The total required critical care experience must not exceed eight months, and must include at least three months in pediatrics and at least two months in internal medicine. (Core)
IV.C.8.	Internal Medicine Component The training in internal medicine for the combined program must include:	4.11.f.	Internal Medicine Component The training in internal medicine for the combined program must include 20 months of direct patient care or supervision of more junior residents in direct patient care. (Core)
IV.C.8.a)	20 months of direct patient care or supervision of more junior residents in direct patient care; (Core)	4.11.f.	Internal Medicine Component The training in internal medicine for the combined program must include 20 months of direct patient care or supervision of more junior residents in direct patient care. (Core)
IV.C.8.b)	experience in the Emergency Department; (Core)	4.11.f.1.	The training in internal medicine for the combined program must include experience in the Emergency Department. (Core)
IV.C.8.b).(1)	This should include at least a one-month experience in the Emergency Department during the first or second year. (Detail)	4.11.f.1.a.	This should include at least a one-month experience in the Emergency Department during the first or second year. (Detail)
IV.C.8.c)	clinical experiences with hospitalized patients; (Core)	4.11.f.2.	The training in internal medicine for the combined program must include clinical experiences with hospitalized patients. (Core)
IV.C.8.c).(1)	At least one-third of the residency training must occur in the ambulatory setting and at least one-third must occur in the inpatient setting. (Core)	4.11.f.3.	At least one-third of the residency training must occur in the ambulatory setting and at least one-third must occur in the inpatient setting. (Core)
IV.C.8.c).(2)	The inpatient experience should be at least eight months in duration. (Detail)	4.11.f.4.	The inpatient experience should be at least eight months in duration. (Detail)
IV.C.8.c).(3)	While on inpatient medicine rotations:	[None]	

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
IV.C.8.c).(3).(a)	a first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services; (Core)	4.11.f.4.a.	A first-year resident must not be assig admitting day; an additional two patie house transfers from the medical serv
IV.C.8.c).(3).(b)	a first-year resident must not be assigned more than eight new patients in a 48- hour period; (Core)	4.11.f.4.b.	A first-year resident must not be assig a 48-hour period.(Core)
IV.C.8.c).(3).(c)	a first-year resident must not be responsible for the ongoing care of more than 10 patients; (Core)	4.11.f.4.c.	A first-year resident must not be resp than 10 patients.(Core)
IV.C.8.c).(3).(d)	when supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day, or more than 16 new patients in a 48-hour period; (Core)	4.11.f.4.d.	When supervising more than one first resident must not be responsible for t than 10 new patients and four transfe than 16 new patients in a 48-hour per
IV.C.8.c).(3).(e)	when supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients; (Core)	4.11.f.4.e.	When supervising one first-year reside be responsible for the ongoing care or
IV.C.8.c).(3).(f)	when supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients; (Core)	4.11.f.4.f.	When supervising more than one first resident must not be responsible for the patients.(Core)
IV.C.8.c).(3).(g)	residents must write all orders for patients under their care, with appropriate supervision by the attending physician, except in those emergent circumstances when an attending physician or subspecialty resident writes an order for a resident's patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner; (Core)	4.11.f.4.g.	Residents must write all orders for pa appropriate supervision by the attend emergent circumstances when an atter resident writes an order for a resident subspecialty resident must communic a timely manner.(Core)
IV.C.8.c).(3).(h)	second- or third-year categorical internal medicine residents, or, second-, third- or fourth-year internal medicine-pediatrics residents or other appropriate supervisory physicians (e.g., fellows, or attending physicians) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on site to supervise first-year residents; (Core)	4.11.f.4.h.	Second- or third-year categorical inter third- or fourth-year internal medicine- appropriate supervisory physicians (e with documented experience appropr severity of patient illness must be ava first-year residents on inpatient medic
IV.C.8.c).(3).(i)	each physician of record has the responsibility to make management rounds on his or her patients and to communicate effectively with the residents participating in the care of these patients at a frequency appropriate to the changing care needs of the patients; (Core)	4.11.f.4.i.	Each physician of record has the resp rounds on his or her patients and to c residents participating in the care of the appropriate to the changing care need medicine rotations. (Core)
IV.C.8.c).(3).(j)	residents' service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. (N. B. : Teaching Service is defined as those patients for whom medicine-pediatrics residents routinely provide care); (Core)	4.11.f.4.j.	Residents' service responsibilities mu medicine rotations for whom the teach therapeutic responsibility. (N. B. : Tea patients for whom medicine-pediatrics (Core)
IV.C.8.c).(3).(k)	residents must not be required to relate to an excessive number of attending physicians; and, (Core)	4.11.f.4.k.	Residents on inpatient medicine rotat an excessive number of attending phy
IV.C.8.c).(3).(I)	residents from other specialties must not supervise internal medicine-pediatrics residents on any internal medicine or pediatrics inpatient rotation. (Core)	4.11.f.4.l.	Residents from other specialties on in supervise internal medicine-pediatrics or pediatrics inpatient rotation. (Core)

signed more than five new patients per ients may be assigned if they are inervices.(Core)

signed more than eight new patients in

ponsible for the ongoing care of more

st-year resident, the supervising r the supervision or admission of more fer patients per admitting day, or more eriod.(Core)

ident, the supervising resident must not of more than 14 patients.(Core)

rst-year resident, the supervising r the ongoing care of more than 20

batients under their care, with nding physician, except in those attending physician or subspecialty nt's patient, the attending or nicate his or her action to the resident in

ternal medicine residents, or, second-, ne-pediatrics residents or other (e.g., fellows, or attending physicians) priate to the acuity, complexity, and vailable at all times on site to supervise dicine rotations. (Core)

sponsibility to make management communicate effectively with the f these patients at a frequency eeds of the patients on inpatient

nust be limited to patients on inpatient aching service has diagnostic and eaching Service is defined as those ics residents routinely provide care).

ations must not be required to relate to hysicians. (Core)

inpatient medicine rotations must not ics residents on any internal medicine re)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
			The training in internal medicine for th
IV.C.8.d)	care of adults with various illnesses in critical care units (e.g., intensive care units, cardiac care units, respiratory care units); (Core)	4.11.f.5.	care of adults with various illnesses in care units, cardiac care units, respiration
	Patient care experiences in the critical care units should occur during the first or		Patient care experiences in the critica
IV.C.8.d).(1)	second year and again in subsequent years. (Detail)	4.11.f.5.a.	first or second year and again in subs
IV.C.8.e)	subspecialty experience, including exposure to neurology, that is inpatient, outpatient, or a combination of the two settings; (Core)	4.11.f.6.	The training in internal medicine for the subspecialty experience, including experience,
,	Residents should have at least four months of subspecialty experiences.		Residents should have at least four m
IV.C.8.e).(1)	(Detail)	4.11.f.6.a.	(Detail)
IV.C.8.e).(2)	This experience should include serving as a consultant. (Detail)	4.11.f.6.b.	This experience should include servin
IV.C.8.f)	clinical experience in geriatrics; (Core)	4.11.f.7.	The training in internal medicine for th clinical experience in geriatrics. (Core
IV.C.8.f).(1)	Residents should have at least one geriatrics rotation. (Detail)	4.11.f.7.a.	Residents should have at least one ge
IV.C.8.g)	a maximum of two months of night float over the duration of the program, with no more than one month of night float during any one year of the program; and, (Core)	4.11.f.8.	The training in internal medicine for th maximum of two months of night float with no more than one month of night program. (Core)
IV.C.8.h)	required transplant rotations in dedicated units not to exceed one month in four years. (Detail)	4.11.f.9.	The training in internal medicine for th required transplant rotations in dedica four years. (Detail)
IV.C.9.	Pediatrics Component	4.11.g.	Pediatrics Component A pediatric educational unit must be a longitudinal experience. (Core)
IV.C.9.a)	A pediatric educational unit must be a block (four weeks or one month) or longitudinal experience. (Core)	4.11.g.	Pediatrics Component A pediatric educational unit must be a longitudinal experience. (Core)
IV.C.9.a).(1)	A longitudinal outpatient educational unit should be a minimum of 32 half-day sessions. A longitudinal inpatient educational unit should be a minimum of 200 hours. (Detail)	4.11.g.1.	A longitudinal outpatient educational u day sessions. A longitudinal inpatient minimum of 200 hours. (Detail)
IV.C.9.b)	The pediatrics curriculum must include:	4.11.g.2.	The pediatrics curriculum must include units of inpatient care experiences, inc
IV.C.9.b).(1)	a minimum of nine educational units of inpatient care experiences, including: (Core)	4.11.g.2.	The pediatrics curriculum must include units of inpatient care experiences, include
IV.C.9.b).(1).(a)	pediatric critical care; (Core)	4.11.g.2.a.	pediatric critical care; (Core)
IV.C.9.b).(1).(a).(i)	There should be one educational unit. (Detail)	4.11.g.2.a.i.	There should be one educational unit.
IV.C.9.b).(1).(b)	neonatal intensive care; (Core)	4.11.g.2.b.	neonatal intensive care; (Core)
IV.C.9.b).(1).(b).(i)	There should be two educational units. (Detail)	4.11.g.2.b.i.	There should be two educational units
IV.C.9.b).(1).(c)	inpatient pediatrics; and, (Core)	4.11.g.2.c.	inpatient pediatrics; and, (Core)
IV.C.9.b).(1).(c).(i)	There should be five educational units. (Detail)	4.11.g.2.c.i.	There should be five educational units
IV.C.9.b).(1).(d)	term newborn care. (Core)	4.11.g.2.d.	term newborn care. (Core)
IV.C.9.b).(1).(d).(i)	There should be one educational unit. (Detail)	4.11.g.2.d.i.	There should be one educational unit.
IV.C.9.b).(2)	a minimum of six educational units of additional subspecialty experiences, including: (Core)	4.11.3.	The pediatrics curriculum must include of additional subspecialty experiences
IV.C.9.b).(2).(a)	developmental-behavioral pediatrics; (Core)	4.11.3.a.	developmental-behavioral pediatrics;
IV.C.9.b).(2).(a).(i)	There should be one educational unit. (Detail)	4.11.3.a.i.	There should be one educational unit.

nt Language
the combined program must include in critical care units (e.g., intensive atory care units). (Core)
cal care units should occur during the osequent years. (Detail)
the combined program must include exposure to neurology, that is inpatient, wo settings. (Core)
months of subspecialty experiences.
ing as a consultant. (Detail)
the combined program must include re)
geriatrics rotation. (Detail)
the combined program must include a at over the duration of the program, nt float during any one year of the
the combined program must include cated units not to exceed one month in
a block (four weeks or one month) or
a block (four weeks or one month) or
l unit should be a minimum of 32 half- nt educational unit should be a
de a minimum of nine educational ncluding: (Core)
de a minimum of nine educational ncluding: (Core)
it. (Detail)
its. (Detail)
its. (Detail)
it. (Detail)
de a minimum of six educational units
es, including: (Core)
; (Core)
it. (Detail)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.C.9.b).(2).(b)	adolescent medicine; and, (Core)	4.11.3.b.	adolescent medicine; and, (Core)
IV.C.9.b).(2).(b).(i)	There should be one educational unit. (Detail)	4.11.3.b.i.	There should be one educational unit. (Detail)
			four educational units of four of the following subspecialties: (Core)
IV.C.9.b).(2).(c)	four educational units of four of the following subspecialties: (Core)	4.11.3.c.	<ul> <li>child abuse; (Core)</li> <li>medical genetics; (Core)</li> <li>pediatric allergy and immunology; (Core)</li> <li>pediatric cardiology; (Core)</li> <li>pediatric dermatology; (Core)</li> <li>pediatric endocrinology; (Core)</li> <li>pediatric gastroenterology; (Core)</li> <li>pediatric hematology-oncology; (Core)</li> <li>pediatric infectious diseases; (Core)</li> <li>pediatric nephrology; (Core)</li> <li>pediatric neurology; (Core)</li> </ul>
			four educational units of four of the following subspecialties: (Core) • child abuse; (Core) • medical genetics; (Core) • pediatric allergy and immunology; (Core) • pediatric cardiology; (Core) • pediatric dermatology; (Core) • pediatric endocrinology; (Core) • pediatric gastroenterology; (Core) • pediatric hematology-oncology; (Core) • pediatric infectious diseases; (Core)
IV.C.9.b).(2).(c).(i)	child abuse; (Core)	4.11.3.c.	<ul> <li>pediatric nephrology; (Core)</li> <li>pediatric neurology; (Core)</li> <li>pediatric pulmonology; or, (Core)</li> <li>pediatric rheumatology. (Core)</li> </ul>

Roman Numeral			
Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requirement Language
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			• pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			pediatric dermatology; (Core)
			<ul> <li>pediatric endocrinology; (Core)</li> </ul>
			pediatric gastroenterology; (Core)
			<ul> <li>pediatric hematology-oncology; (Core)</li> </ul>
			pediatric infectious diseases; (Core)
			pediatric nephrology; (Core)
			<ul> <li>pediatric neurology; (Core)</li> </ul>
			<ul> <li>pediatric pulmonology; or, (Core)</li> </ul>
IV.C.9.b).(2).(c).(ii)	medical genetics; (Core)	4.11.3.c.	<ul> <li>pediatric rheumatology. (Core)</li> </ul>
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			• pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			pediatric dermatology; (Core)
			<ul> <li>pediatric endocrinology; (Core)</li> </ul>
			<ul> <li>pediatric gastroenterology; (Core)</li> </ul>
			<ul> <li>pediatric hematology-oncology; (Core)</li> </ul>
			<ul> <li>pediatric infectious diseases; (Core)</li> </ul>
			<ul> <li>pediatric nephrology; (Core)</li> </ul>
			<ul> <li>pediatric neurology; (Core)</li> </ul>
			<ul> <li>pediatric pulmonology; or, (Core)</li> </ul>
IV.C.9.b).(2).(c).(iii)	pediatric allergy and immunology; (Core)	4.11.3.c.	<ul> <li>pediatric rheumatology. (Core)</li> </ul>
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			• pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			pediatric dermatology; (Core)
			pediatric endocrinology; (Core)
			<ul> <li>pediatric gastroenterology; (Core)</li> </ul>
			<ul> <li>pediatric hematology-oncology; (Core)</li> </ul>
			<ul> <li>pediatric infectious diseases; (Core)</li> </ul>
			<ul> <li>pediatric nephrology; (Core)</li> </ul>
			• pediatric neurology; (Core)
			<ul> <li>pediatric pulmonology; or, (Core)</li> </ul>
IV.C.9.b).(2).(c).(iv)	pediatric cardiology; (Core)	4.11.3.c.	<ul> <li>pediatric rheumatology. (Core)</li> </ul>

Roman Numeral			
Requirement		Reformatted	
Number	Requirement Language	<b>Requirement Number</b>	Requirement Language
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			• pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			• pediatric dermatology; (Core)
			pediatric endocrinology; (Core)
			• pediatric gastroenterology; (Core)
			• pediatric hematology-oncology; (Core)
			• pediatric infectious diseases; (Core)
			• pediatric nephrology; (Core)
			• pediatric neurology; (Core)
			• pediatric pulmonology; or, (Core)
IV.C.9.b).(2).(c).(v)	pediatric dermatology; (Core)	4.11.3.c.	• pediatric rheumatology. (Core)
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			<ul> <li>pediatric dermatology; (Core)</li> <li>pediatric endocrinology; (Core)</li> </ul>
			pediatric gastroenterology; (Core)
			pediatric hematology-oncology; (Core)
			• pediatric infectious diseases; (Core)
			• pediatric nephrology; (Core)
			• pediatric neurology; (Core)
$   \langle (0, 0, k) \rangle \langle (0, 1) \rangle \langle (k) \rangle$	nadiatuia andaaninalamuu (Cana)	4 4 4 0 -	• pediatric pulmonology; or, (Core)
IV.C.9.b).(2).(c).(vi)	pediatric endocrinology; (Core)	4.11.3.c.	• pediatric rheumatology. (Core)
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			• pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			• pediatric dermatology; (Core)
			• pediatric endocrinology; (Core)
			pediatric gastroenterology; (Core)
			pediatric hematology-oncology; (Core)
			• pediatric infectious diseases; (Core)
			pediatric nephrology; (Core)
			• pediatric neurology; (Core)
			• pediatric pulmonology; or, (Core)
IV.C.9.b).(2).(c).(vii)	pediatric gastroenterology; (Core)	4.11.3.c.	pediatric rheumatology. (Core)

Roman Numeral			
Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requirement Language
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			• pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			pediatric dermatology; (Core)
			<ul> <li>pediatric endocrinology; (Core)</li> </ul>
			<ul> <li>pediatric gastroenterology; (Core)</li> </ul>
			<ul> <li>pediatric hematology-oncology; (Core)</li> </ul>
			<ul> <li>pediatric infectious diseases; (Core)</li> </ul>
			<ul> <li>pediatric nephrology; (Core)</li> </ul>
			<ul> <li>pediatric neurology; (Core)</li> </ul>
			<ul> <li>pediatric pulmonology; or, (Core)</li> </ul>
IV.C.9.b).(2).(c).(viii)	pediatric hematology-oncology; (Core)	4.11.3.c.	<ul> <li>pediatric rheumatology. (Core)</li> </ul>
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			• pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			pediatric dermatology; (Core)
			<ul> <li>pediatric endocrinology; (Core)</li> </ul>
			<ul> <li>pediatric gastroenterology; (Core)</li> </ul>
			<ul> <li>pediatric hematology-oncology; (Core)</li> </ul>
			<ul> <li>pediatric infectious diseases; (Core)</li> </ul>
			<ul> <li>pediatric nephrology; (Core)</li> </ul>
			<ul> <li>pediatric neurology; (Core)</li> </ul>
			<ul> <li>pediatric pulmonology; or, (Core)</li> </ul>
IV.C.9.b).(2).(c).(ix)	pediatric infectious diseases; (Core)	4.11.3.c.	<ul> <li>pediatric rheumatology. (Core)</li> </ul>
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			• pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			• pediatric dermatology; (Core)
			• pediatric endocrinology; (Core)
			• pediatric gastroenterology; (Core)
			pediatric hematology-oncology; (Core)
			• pediatric infectious diseases; (Core)
			• pediatric nephrology; (Core)
			• pediatric neurology; (Core)
			pediatric pulmonology; or, (Core)
IV.C.9.b).(2).(c).(x)	pediatric nephrology; (Core)	4.11.3.c.	<ul> <li>pediatric rheumatology. (Core)</li> </ul>

Roman Numeral			
Requirement		Reformatted	
Number	Requirement Language	<b>Requirement Number</b>	Requirement Language
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			<ul> <li>pediatric allergy and immunology; (Core)</li> </ul>
			<ul> <li>pediatric cardiology; (Core)</li> </ul>
			<ul> <li>pediatric dermatology; (Core)</li> </ul>
			<ul> <li>pediatric endocrinology; (Core)</li> </ul>
			<ul> <li>pediatric gastroenterology; (Core)</li> </ul>
			<ul> <li>pediatric hematology-oncology; (Core)</li> </ul>
			<ul> <li>pediatric infectious diseases; (Core)</li> </ul>
			<ul> <li>pediatric nephrology; (Core)</li> </ul>
			• pediatric neurology; (Core)
			<ul> <li>pediatric pulmonology; or, (Core)</li> </ul>
IV.C.9.b).(2).(c).(xi) p	pediatric neurology; (Core)	4.11.3.c.	pediatric rheumatology. (Core)
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			<ul> <li>pediatric allergy and immunology; (Core)</li> </ul>
			• pediatric cardiology; (Core)
			• pediatric dermatology; (Core)
			pediatric endocrinology; (Core)
			• pediatric gastroenterology; (Core)
			• pediatric hematology-oncology; (Core)
			• pediatric infectious diseases; (Core)
			pediatric nephrology; (Core)
			• pediatric neurology; (Core)
$   \setminus (C, 0, h) (2) (a) (xii)$	adietrie nulmenelegy er (Care)	4 11 2 0	pediatric pulmonology; or, (Core)
IV.C.9.b).(2).(c).(xii) p	pediatric pulmonology; or, (Core)	4.11.3.c.	pediatric rheumatology. (Core)
			four educational units of four of the following subspecialties: (Core)
			• child abuse; (Core)
			• medical genetics; (Core)
			pediatric allergy and immunology; (Core)
			• pediatric cardiology; (Core)
			• pediatric dermatology; (Core)
			pediatric endocrinology; (Core)
			• pediatric gastroenterology; (Core)
			<ul> <li>pediatric gastesinereisgy, (core)</li> <li>pediatric hematology-oncology; (Core)</li> </ul>
			pediatric infectious diseases; (Core)
			• pediatric nephrology; (Core)
		1	······································
			• pediatric neurology: (Core)
			<ul> <li>pediatric neurology; (Core)</li> <li>pediatric pulmonology; or, (Core)</li> </ul>

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
IV.C.9.b).(3)	a minimum of four educational units of ambulatory experiences, including: (Core)	4.11.4.	The pediatrics curriculum must include of ambulatory experiences, including:
IV.C.9.b).(3).(a)	two educational units of emergency medicine (one educational unit of emergency medicine is equivalent to 160 hours); and, (Detail)	4.11.4.a.	two educational units of emergency m emergency medicine is equivalent to <sup>2</sup>
IV.C.9.b).(3).(a).(i)	Residents should have first-contact evaluation of pediatric patients in the Emergency Department. (Detail)	4.11.4.a.i.	Residents should have first-contact ev Emergency Department. (Detail)
IV.C.9.b).(3).(b)	two educational units of ambulatory experiences, to include elements of community pediatrics and child advocacy. (Detail)	4.11.4.b.	two educational units of ambulatory ex community pediatrics and child advoc
IV.C.9.b).(4)	two educational units as an individualized curriculum. (Core)	4.11.g.5.	The pediatrics curriculum must include individualized curriculum. (Core)
IV.C.9.b).(4).(a)	The individualized curriculum should be determined by the learning needs and career plans of the resident and should be developed through the guidance of a faculty mentor. (Detail)	4.11.g.5.a.	The individualized curriculum should be and career plans of the resident and s guidance of a faculty mentor. (Detail)
IV.D.	Scholarship Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching. The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.	[None]	Scholarship Medicine is both an art and a scient scientist who cares for patients. Th critically, evaluate the literature, ap knowledge, and practice lifelong lea must create an environment that fo through resident participation in sc activities may include discovery, in teaching. The ACGME recognizes the diversit that programs prepare physicians f clinicians, scientists, and educators scholarship will reflect its mission (community it serves. For example, their scholarly activity on quality in and/or teaching, while other programe classic forms of biomedical researce
	Program Peopencibilities	4.13	Program Responsibilities The program must demonstrate evi
IV.D.1. IV.D.1.a)	Program Responsibilities The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core) The program must demonstrate evidence of scholarly activities consistent	4.13. 4.13.	consistent with its mission(s) and a Program Responsibilities The program must demonstrate evi consistent with its mission(s) and a
IV.D.1.b)	The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)	4.13.a.	The program, in partnership with its allocate adequate resources to faci involvement in scholarly activities.
IV.D.1.c)	The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)	4.13.b.	The program must advance residen scholarly approach to evidence-base

ide a minimum of four educational units g: (Core)

medicine (one educational unit of 0 160 hours); and, (Detail)

evaluation of pediatric patients in the

experiences, to include elements of ocacy. (Detail)

ide: two educational units as an

be determined by the learning needs should be developed through the

ence. The physician is a humanistic This requires the ability to think appropriately assimilate new learning. The program and faculty fosters the acquisition of such skills scholarly activities. Scholarly integration, application, and

sity of residencies and anticipates s for a variety of roles, including ors. It is expected that the program's n(s) and aims, and the needs of the e, some programs may concentrate improvement, population health, rams might choose to utilize more arch as the focus for scholarship.

vidence of scholarly activities l aims. (Core)

vidence of scholarly activities I aims. (Core)

its Sponsoring Institution, must cilitate resident and faculty s. (Core)

ents' knowledge and practice of the ased patient care. (Core)

Roman Numeral			
Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requirement Language
			Faculty Scholarly Activity Among their scholarly activity, programs must demonstrate
			accomplishments in at least three of the following domains: (Core)
			• Research in basic science, education, translational science, patient care, or population health
			• Peer-reviewed grants
			Quality improvement and/or patient safety initiatives     Systematic reviews, meta analysiss, review, articles, shorters in
			<ul> <li>Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports</li> </ul>
			Creation of curricula, evaluation tools, didactic educational
			activities, or electronic educational materials
			• Contribution to professional committees, educational organizations,
			or editorial boards
IV.D.2.	Faculty Scholarly Activity	4.14.	Innovations in education
			Faculty Scholarly Activity
	Among their scholarly activity, programs must demonstrate		Among their scholarly activity, programs must demonstrate
	accomplishments in at least three of the following domains: (Core)		accomplishments in at least three of the following domains: (Core)
	• Research in basic science, education, translational science, patient care,		• Research in basic science, education, translational science, patient
	or population health		care, or population health
	• Peer-reviewed grants		• Peer-reviewed grants
	• Quality improvement and/or patient safety initiatives		• Quality improvement and/or patient safety initiatives
	• Systematic reviews, meta-analyses, review articles, chapters in medical		• Systematic reviews, meta-analyses, review articles, chapters in
	textbooks, or case reports		medical textbooks, or case reports
	• Creation of curricula, evaluation tools, didactic educational activities, or		<ul> <li>Creation of curricula, evaluation tools, didactic educational</li> </ul>
	electronic educational materials		activities, or electronic educational materials
	Contribution to professional committees, educational organizations, or		• Contribution to professional committees, educational organizations,
	editorial boards		or editorial boards
IV.D.2.a)	Innovations in education	4.14.	Innovations in education
			The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:
			<ul> <li>faculty participation in grand rounds, posters, workshops, quality</li> </ul>
			improvement presentations, podium presentations, grant leadership,
			non-peer-reviewed print/electronic resources, articles or publications,
			book chapters, textbooks, webinars, service on professional
			committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)
	The preason must domonstrate discomination of a help by activity with it		<ul> <li>peer-reviewed publication. (Outcome)</li> </ul>
IV D 2 b)	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:	111 2	
IV.D.2.b)	and external to the program by the following methods:	4.14.a.	

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.D.2.b).(1)	faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non- peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)		<ul> <li>The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:</li> <li>faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)</li> <li>peer-reviewed publication. (Outcome)</li> </ul>
			<ul> <li>The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:</li> <li>faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)</li> <li>peer-reviewed publication. (Outcome)</li> </ul>
IV.D.2.b).(2)			Resident Scholarly Activity
IV.D.3. IV.D.3.a)	Resident Scholarly Activity Residents must participate in scholarship. (Core)		Residents must participate in scholarship. (Core) Resident Scholarly Activity Residents must participate in scholarship. (Core)
V.	Evaluation	Section 5	Section 5: Evaluation
V.A.	Resident Evaluation		Resident Evaluation: Feedback and Evaluation Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)
V.A.1.	Feedback and Evaluation		Resident Evaluation: Feedback and Evaluation Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)
V.A.1.a)	Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar		Resident Evaluation: Feedback and Evaluation Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)
V.A.1.a).(1)	Residents must be evaluated utilizing a structured approach by faculty members or other appropriate supervisors using multiple assessment methods, in different settings, for: (Core)		Residents must be evaluated utilizing a structured approach by faculty members or other appropriate supervisors using multiple assessment methods, in different settings, for: (Core)
V.A.1.a).(1).(a)	performing histories and physical examinations; (Detail)	5.1.i.1.	performing histories and physical examinations; (Detail)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
V.A.1.a).(1).(b)	providing effective counseling of patients and families on the broad range of issues; and, (Detail)	5.1.i.2.	providing effective counseling of patie of issues; and, (Detail)
V.A.1.a).(1).(c)	demonstrating the ability to make diagnostic and therapeutic decisions based on best evidence and to develop and carry out management plans. (Detail)	5.1.i.3.	demonstrating the ability to make diag based on best evidence and to develo (Detail)
V.A.1.b)	Evaluation must be documented at the completion of the assignment. (Core)	5.1.a.	Evaluation must be documented at (Core)
V.A.1.b).(1)	For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)	5.1.a.1.	For block rotations of greater than tevaluation must be documented at
V.A.1.b).(2)	Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)	5.1.a.2.	Longitudinal experiences, such as o other clinical responsibilities, must months and at completion. (Core)
V.A.1.c)	The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)	5.1.b.	The program must provide an object based on the Competencies and the (Core)
V.A.1.c).(1)	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)	5.1.b.1.	The program must use multiple eva peers, patients, self, and other profe
V.A.1.c).(1).(a)	Assessment of residents' communication skills and professionalism should include evaluations by patients and/or patients' families. (Detail)	5.1.b.1.a.	Assessment of residents' communicat include evaluations by patients and/or
V.A.1.c).(2)	provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)	5.1.b.2.	The program must provide that info Competency Committee for its synt performance and improvement towa
V.A.1.c).(3)	This assessment should involve direct observation of resident-patient encounters. (Detail)	5.1.b.2.a.	This assessment should involve direct encounters. (Detail)
V.A.1.c).(4)	The program should use an objective validated formative assessment method (e.g., in-training examination, chart stimulated recall). (Detail)	5.1.b.2.b.	The program should use an objective method (e.g., in-training examination,
V.A.1.c).(4).(a)	The same formative assessment method should be administered annually for each specialty. (Detail)	5.1.b.2.c.	The same formative assessment meth for each specialty. (Detail)
V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:	[None]	
V.A.1.d).(1)	meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)	5.1.c.	The program director or their design Competency Committee, must meet resident their documented semi-and including progress along the specia
V.A.1.d).(2)	assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)	5.1.d.	The program director or their design Competency Committee, must assist individualized learning plans to cap identify areas for growth. (Core)
V.A.1.d).(2).(a)	create and document an individualized learning plan at least annually. (Core)	5.1.d.1.	The program director or their designed Competency Committee, must create learning plan at least annually. (Core)
V.A.1.d).(2).(a).(i)	The program should provide a system to assist residents in this process, including: (Detail)	5.1.d.2.	The program should provide a system including: (Detail)
V.A.1.d).(2).(a).(i).(a) V.A.1.d).(2).(a).(i).(b)	faculty mentorship to help residents create learning goals; and, (Detail) systems for tracking and monitoring progress toward completing the individualized learning plan. (Detail)	5.1.d.2.a. 5.1.d.2.b.	faculty mentorship to help residents cr systems for tracking and monitoring pr individualized learning plan. (Detail)

ients and families on the broad range

agnostic and therapeutic decisions lop and carry out management plans.

at the completion of the assignment.

n three months in duration, at least every three months. (Core) s continuity clinic in the context of st be evaluated at least every three

ective performance evaluation he specialty-specific Milestones.

valuators (e.g., faculty members, ofessional staff members). (Core) ation skills and professionalism should or patients' families. (Detail)

formation to the Clinical nthesis of progressive resident ward unsupervised practice. (Core) ect observation of resident-patient

e validated formative assessment n, chart stimulated recall). (Detail) ethod should be administered annually

ignee, with input from the Clinical eet with and review with each innual evaluation of performance, cialty-specific Milestones. (Core)

ignee, with input from the Clinical sist residents in developing apitalize on their strengths and

uee, with input from the Clinical te and document an individualized e)

m to assist residents in this process,

create learning goals; and, (Detail) progress toward completing the

Roman Numeral Requirement	Demuinement Lennueme	Reformatted	
Number V.A.1.d).(3)	Requirement Language develop plans for residents failing to progress, following institutional policies and procedures. (Core)	Requirement Number	Requirement LanguageThe program director or their designee, with input from the ClinicalCompetency Committee, must develop plans for residents failing toprogress, following institutional policies and procedures. (Core)
V.A.1.e)	At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)	f 5.1.f.	At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)
V.A.1.f)	The evaluations of a resident's performance must be accessible for review by the resident. (Core)	5.1.g.	The evaluations of a resident's performance must be accessible for review by the resident. (Core)
V.A.1.g)	The record of evaluation should include a logbook or an equivalent method to document that each resident has achieved sufficient experience performing invasive procedures to achieve competence. (Detail)	5.1.h.	The record of evaluation should include a logbook or an equivalent method to document that each resident has achieved sufficient experience performing invasive procedures to achieve competence. (Detail)
			Resident Evaluation: Final Evaluation
V.A.2.	Final Evaluation	5.2.	The program director must provide a final evaluation for each resident upon completion of the program. (Core)
			Resident Evaluation: Final Evaluation
V.A.2.a)	The program director must provide a final evaluation for each resident upon completion of the program. (Core)	5.2.	The program director must provide a final evaluation for each resident upon completion of the program. (Core)
V.A.2.a).(1)	The specialty-specific Milestones, and when applicable the specialty- specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)	5.2.a.	The specialty-specific Milestones, and when applicable the specialty- specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)
V.A.2.a).(2)	The final evaluation must:	[None]	
V.A.2.a).(2).(a)	become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)	5.2.b.	The final evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. (Core)
V.A.2.a).(2).(b)	verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core)
V.A.2.a).(2).(c)	be shared with the resident upon completion of the program. (Core)	5.2.d.	The final evaluation must be shared with the resident upon completion of the program. (Core)
V.A.3.	A Clinical Competency Committee must be appointed by the program director. (Core)	5.3.	Clinical Competency Committee A Clinical Competency Committee must be appointed by the program director. (Core)
V.A.3.a)	At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)	5.3.a.	At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)
V.A.3.a).(1)	Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)	5.3.b.	Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)
V.A.3.b)	The Clinical Competency Committee must:	[None]	
Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	
--	---	-----------------------------------	--
V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)	5.3.c.	The Clinical Competency Committe evaluations at least semi-annually.
V.A.3.b).(2)	determine each resident's progress on achievement of the specialty- specific Milestones; and, (Core)	5.3.d.	The Clinical Competency Committe progress on achievement of the sp
V.A.3.b).(3)	meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)	5.3.e.	The Clinical Competency Committee semi-annual evaluations and advise each resident's progress. (Core)
V.B.	Faculty Evaluation	5.4.	Faculty Evaluation The program must have a process performance as it relates to the edu annually. (Core)
V.B.1.	The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)	5.4.	Faculty Evaluation The program must have a process performance as it relates to the edu annually. (Core)
V.B.1.a)	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)	5.4.a.	This evaluation must include a revi teaching abilities, engagement with participation in faculty developmen educator, clinical performance, pro activities. (Core)
V.B.1.b)	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)	5.4.b.	This evaluation must include writte evaluations by the residents. (Core
V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feed annually. (Core)
V.B.3.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)	5.4.d.	Results of the faculty educational e into program-wide faculty developm
V.C.	Program Evaluation and Improvement	5.5.	Program Evaluation and Improvem The program director must appoint Committee to conduct and docume as part of the program's continuous
V.C.1.	The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)	5.5.	Program Evaluation and Improvem The program director must appoint Committee to conduct and docume as part of the program's continuous
V.C.1.a)	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)	5.5.a.	The Program Evaluation Committee program faculty members, at least member, and at least one resident.
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
V.C.1.b).(1)	review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee res of the program's self-determined go them. <sup>(Core)</sup>
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee res ongoing program improvement, inc based upon outcomes. (Core)

nt Language
tee must review all resident
v. (Core)
tee must determine each resident's
pecialty-specific Milestones. (Core)
tee must meet prior to the residents'
se the program director regarding
s to evaluate each faculty member's
lucational program at least
F - 5
s to evaluate each faculty member's
lucational program at least
iucational program at least
view of the faculty member's clinical
th the educational program,
ent related to their skills as an
ofessionalism, and scholarly
· · · · · · · · · · · · · · · · · · ·
en, anonymous, and confidential
e)
edback on their evaluations at least
euback off their evaluations at least
avaluations abould be incorporated
evaluations should be incorporated
oment plans. (Core)
nent
nt the Program Evaluation
ent the Annual Program Evaluation
us improvement process. (Core)
nent
nt the Program Evaluation
ent the Annual Program Evaluation
us improvement process. (Core)
ee must be composed of at least two
t one of whom is a core faculty
t. (Core)
ononoihilitioo muot include review
-
-
-
esponsibilities must include review goals and progress toward meeting esponsibilities must include guiding
goals and progress toward meeting

Requirement Language	Reformatted Requirement Number	Requirement
review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee res of the current operating environme challenges, opportunities, and thre mission and aims. (Core)
evaluations of the program, and other relevant data in its assessment of		The Program Evaluation Committee from prior Annual Program Evaluat faculty written evaluations of the pr its assessment of the program. (Co
The Program Evaluation Committee must evaluate the program's mission		The Program Evaluation Committee mission and aims, strengths, areas (Core)
The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)	5.5.g.	The Annual Program Evaluation, in distributed to and discussed with the the teaching faculty, and be submit
The program must complete a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must complete a Self- (Core)
One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.	[None]	Board Certification One goal of ACGME-accredited edu who seek and achieve board certific effectiveness of the educational pro The program director should encou graduates to take the certifying exa American Board of Medical Special American Osteopathic Association
time must be higher than the bottom fifth percentile of programs in that		Board Certification For specialties in which the ABMS certifying board offer(s) an annual three years, the program's aggrega examination for the first time must percentile of programs in that spec
time must be higher than the bottom fifth percentile of programs in that		For specialties in which the ABMS is certifying board offer(s) a biennial w years, the program's aggregate pas examination for the first time must percentile of programs in that speci
time must be higher than the bottom fifth percentile of programs in that		For specialties in which the ABMS certifying board offer(s) an annual of years, the program's aggregate past examination for the first time must percentile of programs in that spec
	<ul> <li>challenges, opportunities, and threats as related to the program's mission and aims. (Core)</li> <li>The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)</li> <li>The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)</li> <li>The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)</li> <li>The program must complete a Self-Study and submit it to the DIO. (Core)</li> <li>One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.</li> <li>The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)</li> <li>For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)</li> <li>For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that</li></ul>	Requirement Language         Requirement Number           review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)         5.5.d.           The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)         5.5.e.           The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)         5.5.f.           The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)         5.5.g.           The program must complete a Self-Study and submit it to the DIO. (Core)         5.5.h.           One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.         Interprogram graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)         5.6.           For specialties in which the ABMS member board and/or AOA certifying board offer(s) a anonual written exam, in the preceding sity years, the program's aggregate pass

esponsibilities must include review nent to identify strengths, reats as related to the program's

ee should consider the outcomes ation(s), aggregate resident and program, and other relevant data in Core)

ee must evaluate the program's as for improvement, and threats.

including the action plan, must be the residents and the members of hitted to the DIO. (Core)

If-Study and submit it to the DIO.

ducation is to educate physicians ification. One measure of the program is the ultimate pass rate.

ourage all eligible program xamination offered by the applicable alties (ABMS) member board or on (AOA) certifying board.

S member board and/or AOA Il written exam, in the preceding gate pass rate of those taking the st be higher than the bottom fifth ecialty. (Outcome)

S member board and/or AOA Il written exam, in the preceding six ass rate of those taking the st be higher than the bottom fifth ecialty. <sup>(Outcome)</sup>

S member board and/or AOA al oral exam, in the preceding three ass rate of those taking the st be higher than the bottom fifth ∋cialty. <sup>(Outcome)</sup>

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first		For specialties in which the ABMS certifying board offer(s) a biennial of years, the program's aggregate pas
V.C.3.d)	time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.c.	examination for the first time must percentile of programs in that spec
V.C.3.e)	For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)	5.6.d.	For each of the exams referenced in graduates over the time period spec- achieved an 80 percent pass rate w matter the percentile rank of the pro- specialty. <sup>(Outcome)</sup>
V.C.3.f)	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)	5.6.e.	Programs must report, in ADS, boa the cohort of board-eligible residen earlier. <sup>(Core)</sup>
			Section 6: The Learning and Workir
	The Learning and Working Environment		The Learning and Working Environ
	Residency education must occur in the context of a learning and working environment that emphasizes the following principles:		Residency education must occur in working environment that emphasized
	<ul> <li>Excellence in the safety and quality of care rendered to patients by residents today</li> </ul>		<ul> <li>Excellence in the safety and qualities residents today</li> </ul>
	<ul> <li>Excellence in the safety and quality of care rendered to patients by today's residents in their future practice</li> </ul>		• Excellence in the safety and qualit today's residents in their future pra
	• Excellence in professionalism		• Excellence in professionalism
	• Appreciation for the privilege of caring for patients		• Appreciation for the privilege of ca
VI.	<ul> <li>Commitment to the well-being of the students, residents, faculty members, and all members of the health care team</li> </ul>	Section 6	<ul> <li>Commitment to the well-being of t members, and all members of the h</li> </ul>
VI.A.	Patient Safety, Quality Improvement, Supervision, and Accountability	[None]	
VI.A.1.	Patient Safety and Quality Improvement	[None]	
VI.A.1.a)	Patient Safety	[None]	
VI.A.1.a).(1)	Culture of Safety A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.	[None]	Culture of Safety A culture of safety requires continu vulnerabilities and a willingness to effective organization has formal m knowledge, skills, and attitudes of i order to identify areas for improven
VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)		The program, its faculty, residents, participate in patient safety system safety. (Core)

nt Language	
-------------	--

S member board and/or AOA Il oral exam, in the preceding six ass rate of those taking the st be higher than the bottom fifth ecialty. <sup>(Outcome)</sup>

I in 5.6.a.-c., any program whose becified in the requirement have will have met this requirement, no brogram for pass rate in that

oard certification status annually for ents that graduated seven years

king Environment

onment

*in the context of a learning and sizes the following principles:* 

ality of care rendered to patients by

nlity of care rendered to patients by ractice

caring for patients

f the students, residents, faculty health care team

nuous identification of to transparently deal with them. An mechanisms to assess the f its personnel toward safety in ement.

s, and fellows must actively ms and contribute to a culture of

Roman Numeral Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requiremen
	Patient Safety Events		Patient Safety Events Reporting, investigation, and follow
	Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety,		and unsafe conditions are pivotal n safety, and are essential for the suc
	and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based		program. Feedback and experientia developing true competence in the institute sustainable systems-base
VI.A.1.a).(2)	changes to ameliorate patient safety vulnerabilities.	[None]	safety vulnerabilities.
	Residents, fellows, faculty members, and other clinical staff members		
VI.A.1.a).(2).(a)	must:	[None]	
VI.A.1.a).(2).(a).(i)	know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)	6.2.	Residents, fellows, faculty member must know their responsibilities in and unsafe conditions at the clinica such events. (Core)
VI.A.1.a).(2).(a).(ii)	be provided with summary information of their institution's patient safety reports. (Core)	6.2.a.	Residents, fellows, faculty member must be provided with summary int patient safety reports. <sup>(Core)</sup>
VI.A.1.a).(2).(b)	Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)	6.3.	Residents must participate as team interprofessional clinical patient sa activities, such as root cause analy analysis, as well as formulation and
	Quality Metrics Access to data is essential to prioritizing activities for care improvement		Quality Metrics Access to data is essential to prior
VI.A.1.a).(3)	and evaluating success of improvement efforts.	[None]	improvement and evaluating succe
VI.A.1.a).(3).(a)	Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)	6.4.	Residents and faculty members mu and benchmarks related to their pa
			Supervision and Accountability Although the attending physician is care of the patient, every physician accountability for their efforts in th programs, in partnership with their widely communicate, and monitor a and accountability as it relates to th
			Supervision in the setting of gradu safe and effective care to patients; development of the skills, knowled the unsupervised practice of medic
VI.A.2.	Supervision and Accountability	[None]	for continued professional growth.

ow-up of safety events, near misses, I mechanisms for improving patient uccess of any patient safety tial learning are essential to be ability to identify causes and sed changes to ameliorate patient

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

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

m members in real and/or simulated safety and quality improvement lyses or other activities that include nd implementation of actions. (Core)

oritizing activities for care cess of improvement efforts. nust receive data on quality metrics patient populations. (Core)

is ultimately responsible for the an shares in the responsibility and the provision of care. Effective ir Sponsoring Institutions, define, r a structured chain of responsibility the supervision of all patient care.

luate medical education provides s; ensures each resident's edge, and attitudes required to enter licine; and establishes a foundation h.

Roman Numeral Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requiremen
	Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.		Supervision and Accountability Although the attending physician i care of the patient, every physician accountability for their efforts in the programs, in partnership with their widely communicate, and monitor and accountability as it relates to t
VI.A.2.a)	Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.	[None]	Supervision in the setting of gradu safe and effective care to patients; development of the skills, knowled the unsupervised practice of medic for continued professional growth.
VI.A.2.a).(1)	Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)	6.5.	Residents and faculty members murespective roles in that patient's cacare. This information must be availy members, other members of the here (Core)
VI.A.2.a).(1).(a)	This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)	6.5.	Residents and faculty members murespective roles in that patient's care. This information must be ava members, other members of the here (Core)
VI.A.2.a).(2)	The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)	6.6.	The program must demonstrate tha supervision in place for all residen of training and ability, as well as pa Supervision may be exercised thro appropriate to the situation. (Core)
VI.A.2.b)	Levels of Supervision To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:	[None]	Levels of Supervision To promote appropriate resident su graded authority and responsibility following classification of supervis
			Direct Supervision The supervising physician is physi during the key portions of the patie
VI.A.2.b).(1)	Direct Supervision:	6.7.	The supervising physician and/or p with the resident and the supervisi monitoring the patient care through technology.

n is ultimately responsible for the an shares in the responsibility and the provision of care. Effective eir Sponsoring Institutions, define, or a structured chain of responsibility the supervision of all patient care.

duate medical education provides s; ensures each resident's edge, and attitudes required to enter dicine; and establishes a foundation th.

must inform each patient of their care when providing direct patient vailable to residents, faculty health care team, and patients.

must inform each patient of their care when providing direct patient vailable to residents, faculty health care team, and patients.

that the appropriate level of ents is based on each resident's level patient complexity and acuity. rough a variety of methods, as e)

supervision while providing for lity, the program must use the vision.

vsically present with the resident tient interaction.

r patient is not physically present ising physician is concurrently Igh appropriate telecommunication

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
			Direct Supervision The supervising physician is physically present with the resident during the key portions of the patient interaction.
VI.A.2.b).(1).(a)	the supervising physician is physically present with the resident during the key portions of the patient interaction; or,	6.7.	The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
VI.A.2.b).(1).(a).(i)	PGY-1 residents must initially be supervised directly, only as described in VI.A.2.b).(1).(a). (Core)	6.7.a.	PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core)
			Direct Supervision The supervising physician is physically present with the resident during the key portions of the patient interaction.
VI.A.2.b).(1).(b)	the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.	6.7.	The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
VI.A.2.b).(2)	Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.	[None]	Indirect Supervision The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.
VI.A.2.b).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.	[None]	Oversight The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physical presence of a supervising physician is required. (Core)
VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)	6.9.	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)
VI.A.2.d).(1)	The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)	6.9.a.	The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)
VI.A.2.d).(2)	Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)	6.9.b.	Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)
VI.A.2.d).(3)	Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)	6.9.c.	Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)
VI.A.2.e)	Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)	6.10.	Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

Roman Numeral		Deformatted	
Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
VI.A.2.e).(1)	Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)	6.10.a.	Each resident must know the limits the circumstances under which the conditional independence. (Outcon
VI.A.2.f)	Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)	6.11.	Faculty supervision assignments m assess the knowledge and skills of the resident the appropriate level o responsibility. (Core)
VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with their educate residents and faculty mem and ethical responsibilities of phys their obligation to be appropriately required by their patients. (Core)
VI.B.1.	Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)	6.12.	Professionalism Programs, in partnership with their educate residents and faculty mem and ethical responsibilities of phys their obligation to be appropriately required by their patients. (Core)
VI.B.2.	The learning objectives of the program must:	[None]	
VI.B.2.a)	be accomplished without excessive reliance on residents to fulfill non- physician obligations; (Core)	6.12.a.	The learning objectives of the prog without excessive reliance on resid obligations. <sup>(Core)</sup>
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the prog patient care responsibilities. (Core)
VI.B.2.c)	include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)	6.12.c.	The learning objectives of the prog enhance the meaning that each res being a physician, including protec administrative support, promoting flexibility, and enhancing professio
VI.B.3.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)	6.12.d.	The program director, in partnershi must provide a culture of professio and personal responsibility. (Core)
VI.B.4.	Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)	6.12.e.	Residents and faculty members mu of their personal role in the safety a their care, including the ability to re events. (Core)
VI.B.5.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)	6.12.f.	Programs, in partnership with their provide a professional, equitable, re that is psychologically safe and tha sexual and other forms of harassme coercion of students, residents, fac
VI.B.6.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)	6.12.g.	Programs, in partnership with their have a process for education of res unprofessional behavior and a con investigating, and addressing such

ts of their scope of authority, and ne resident is permitted to act with ome)

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

Fir Sponsoring Institutions, must mbers concerning the professional vsicians, including but not limited to ly rested and fit to provide the care

Fir Sponsoring Institutions, must mbers concerning the professional vsicians, including but not limited to ly rested and fit to provide the care

gram must be accomplished idents to fulfill non-physician

gram must ensure manageable e)

ogram must include efforts to esident finds in the experience of ecting time with patients, providing g progressive independence and ional relationships. (Core)

hip with the Sponsoring Institution, ionalism that supports patient safety e)

nust demonstrate an understanding and welfare of patients entrusted to report unsafe conditions and safety

Fir Sponsoring Institutions, must respectful, and civil environment hat is free from discrimination, ment, mistreatment, abuse, or aculty, and staff. (Core)

ir Sponsoring Institutions, should esidents and faculty regarding nfidential process for reporting, ch concerns. (Core)

Roman Numeral			
Requirement		Reformatted	
Number	Requirement Language	Requirement Number	Requiremer
	Well Being		Wall Daing
	Well-Being		Well-Being Psychological, emotional, and phy
	Psychological, emotional, and physical well-being are critical in the		development of the competent, car
	development of the competent, caring, and resilient physician and require		require proactive attention to life in
	proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their		being requires that physicians reta managing their own real-life stress
	own real-life stresses. Self-care and responsibility to support other		support other members of the heat
	members of the health care team are important components of		components of professionalism; th
	professionalism; they are also skills that must be modeled, learned, and		modeled, learned, and nurtured in
	nurtured in the context of other aspects of residency training.		residency training.
	Residents and faculty members are at risk for burnout and depression.		Residents and faculty members ar
	Programs, in partnership with their Sponsoring Institutions, have the		depression. Programs, in partners
	same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share		Institutions, have the same respon
	responsibility for the well-being of each other. A positive culture in a		other aspects of resident compete of the health care team share resp
	clinical learning environment models constructive behaviors, and		other. A positive culture in a clinic
	prepares residents with the skills and attitudes needed to thrive		constructive behaviors, and prepa
VI.C.	throughout their careers.	[None]	attitudes needed to thrive through
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program, Institution, must include:
1.0.1.	attention to scheduling, work intensity, and work compression that		attention to scheduling, work inter
VI.C.1.a)	impacts resident well-being; (Core)	6.13.a.	impacts resident well-being; (Core
	evaluating workplace safety data and addressing the safety of residents		evaluating workplace safety data a
VI.C.1.b)	and faculty members; (Core)	6.13.b.	residents and faculty members; (C
VI.C.1.c)	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)	6.13.c.	policies and programs that encour member well-being; and, (Core)
	Residents must be given the opportunity to attend medical, mental health,		Residents must be given the oppo
	and dental care appointments, including those scheduled during their		health, and dental care appointment
VI.C.1.c).(1)	working hours. (Core)	6.13.c.1.	during their working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty
	identification of the symptoms of burnout, depression, and substance use		identification of the symptoms of t
	disorders, suicidal ideation, or potential for violence, including means to		use disorders, suicidal ideation, or
VI.C.1.d).(1)	assist those who experience these conditions; (Core)	6.13.d.1.	means to assist those who experie
	recognition of these symptoms in themselves and how to seek		recognition of these symptoms in
VI.C.1.d).(2)	appropriate care; and, (Core)	6.13.d.2.	appropriate care; and, (Core)
VI.C.1.d).(3)	access to appropriate tools for self-screening. (Core)	6.13.d.3.	access to appropriate tools for sel
l	providing access to confidential, affordable mental health assessment,		providing access to confidential, a
	counseling, and treatment, including access to urgent and emergent care	6 13 0	assessment, counseling, and treat
VI.C.1.e)	24 hours a day, seven days a week. (Core)	6.13.e.	and emergent care 24 hours a day,

hysical well-being are critical in the caring, and resilient physician and e inside and outside of medicine. Welletain the joy in medicine while sses. Self-care and responsibility to ealth care team are important they are also skills that must be in the context of other aspects of

are at risk for burnout and rship with their Sponsoring onsibility to address well-being as tence. Physicians and all members sponsibility for the well-being of each ical learning environment models pares residents with the skills and phout their careers.

n, in partnership with the Sponsoring

ensity, and work compression that re)

and addressing the safety of (Core)

urage optimal resident and faculty

oortunity to attend medical, mental ents, including those scheduled e)

ty members in:

f burnout, depression, and substance or potential for violence, including rience these conditions; (Core)

n themselves and how to seek

elf-screening. (Core)

affordable mental health atment, including access to urgent ly, seven days a week. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Boguiromon
	There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient		There are circumstances in which r work, including but not limited to fa and medical, parental, or caregiver an appropriate length of absence fo
VI.C.2.	care responsibilities. (Core) The program must have policies and procedures in place to ensure	6.14.	patient care responsibilities. (Core) The program must have policies an
VI.C.2.a)	coverage of patient care and ensure continuity of patient care. (Core)	6.14.a.	coverage of patient care and ensure
VI.C.2.b)	These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)	6.14.b.	These policies must be implemente consequences for the resident who clinical work. (Core)
VI.D.	Fatigue Mitigation	6.15.	Fatigue Mitigation Programs must educate all resident recognition of the signs of fatigue a management, and fatigue mitigation
VI.D.1.	Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)	6.15.	Fatigue Mitigation Programs must educate all resident recognition of the signs of fatigue a management, and fatigue mitigation
VI.D.2.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)	6.16.	The program, in partnership with its ensure adequate sleep facilities and residents who may be too fatigued
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
VI.E.1.	Clinical Responsibilities The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)	6.17.	Clinical Responsibilities The clinical responsibilities for eac level, patient safety, resident ability patient illness/condition, and availa
VI.E.1.a)	Residents must be responsible for an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize the educational experience. (Core)	6.17.a.	Residents must be responsible for an patient experiences do not meet educ load suggests an inappropriate reliand obligations, which may jeopardize the
VI.E.2.	Teamwork Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)	6.18.	Teamwork Residents must care for patients in communication and promotes safe, care in the specialty and larger hea
VI.E.3.	Transitions of Care	6.19.	Transitions of Care Programs must design clinical assi patient care, including their safety,
VI.E.3.a)	Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)	6.19.	Transitions of Care Programs must design clinical assi patient care, including their safety,
VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)	6.19.a.	Programs, in partnership with their ensure and monitor effective, struc facilitate both continuity of care and

n residents may be unable to attend fatigue, illness, family emergencies, er leave. Each program must allow for residents unable to perform their e)

and procedures in place to ensure ure continuity of patient care. (Core)

ted without fear of negative to is or was unable to provide the

ents and faculty members in a and sleep deprivation, alertness on processes. (Detail)

ents and faculty members in e and sleep deprivation, alertness on processes. (Detail)

its Sponsoring Institution, must nd safe transportation options for d to safely return home. (Core)

ach resident must be based on PGY ity, severity and complexity of ilable support services. (Core)

In appropriate patient load. Insufficient ucational needs; an excessive patient nce on residents for service ne educational experience. (Core)

in an environment that maximizes fe, interprofessional, team-based ealth system. (Core)

signments to optimize transitions in /, frequency, and structure. (Core)

signments to optimize transitions in y, frequency, and structure. (Core) ir Sponsoring Institutions, must actured hand-off processes to and patient safety. (Core)

Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requirement Language
VI.E.3.c)	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)	6.19.b.	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)
VI.F.	Clinical Experience and Education Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.	[None]	Clinical Experience and Education Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.
VI.F.1.	Maximum Hours of Clinical and Educational Work per Week Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in- house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)	6.20.	Maximum Hours of Clinical and Educational Work per Week Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	Mandatory Time Free of Clinical Work and Education Residents should have eight hours off between scheduled clinical work and education periods. (Detail)
VI.F.2.a)	Residents should have eight hours off between scheduled clinical work and education periods. (Detail)	6.21.	Mandatory Time Free of Clinical Work and Education Residents should have eight hours off between scheduled clinical work and education periods. (Detail)
VI.F.2.b)	Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)	6.21.a.	Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)
VI.F.2.c)	Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). Athome call cannot be assigned on these free days. (Core)	6.21.b.	Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	Maximum Clinical Work and Education Period Length Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)
VI.F.3.a)	Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)	6.22.	Maximum Clinical Work and Education Period Length Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)
VI.F.3.a).(1)	Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)	6.22.a.	Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	Clinical and Educational Work Hour Exceptions In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)

Roman Numeral		Reformatted		
Requirement Number	Requirement Language	Requirement Number	Requirement Language	
VI.F.4.a)	In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)		Clinical and Educational Work Hour Exceptions In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)	
VI.F.4.b)	These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)	6.23.a.	These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)	
	A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. The Review Committees for Internal Medicine and Pediatrics will not consider		A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. The Review Committees for Internal Medicine and Pediatrics will not consider requests for exceptions to the 80-hour limit to the residents' work	
VI.F.4.c) VI.F.5.	requests for exceptions to the 80-hour limit to the residents' work week. Moonlighting	6.24. 6.25.	week. Moonlighting Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)	
VI.F.5.a)	Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)	6.25.	Moonlighting Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)	
VI.F.5.b)	Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)	6.25.a.	Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)	
VI.F.5.c)	PGY-1 residents are not permitted to moonlight. (Core)	6.25.b.	PGY-1 residents are not permitted to moonlight. (Core)	
VI.F.6.	In-House Night Float Night float must occur within the context of the 80-hour and one-day-off-in seven requirements. (Core)	6.26.	In-House Night Float Night float must occur within the context of the 80-hour and one-day- off-in-seven requirements. (Core)	
VI.F.6.a)	Internal Medicine-Pediatrics residency programs must not average in-house call over a four-week period. (Core)	6.26.a.	Internal Medicine-Pediatrics residency programs must not average in- house call over a four-week period. (Core)	
VI.F.7.	Maximum In-House On-Call Frequency Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)	6.27.	Maximum In-House On-Call Frequency Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)	

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
VI.F.8.	At-Home Call	6.28.	At-Home Call Time spent on patient care activitie must count toward the 80-hour may of at-home call is not subject to the must satisfy the requirement for on and education, when averaged over
VI.F.8.a)	Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at- home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)	6.28.	At-Home Call Time spent on patient care activitie must count toward the 80-hour may of at-home call is not subject to the must satisfy the requirement for on and education, when averaged over
VI.F.8.a).(1)	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)	6.28.a.	At-home call must not be so freque reasonable personal time for each

ties by residents on at-home call aximum weekly limit. The frequency he every-third-night limitation, but one day in seven free of clinical work ver four weeks. (Core)

ties by residents on at-home call aximum weekly limit. The frequency he every-third-night limitation, but one day in seven free of clinical work ver four weeks. (Core)

uent or taxing as to preclude rest or h resident. (Core)