Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 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.***
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 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.***

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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.	**[None]**	**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.*
Int.C.	**Length of Educational Program** The educational program in internal medicine-pediatrics must be 48 months in length. (Core)	**4.1.**	**Length of Program** The educational program in internal medicine-pediatrics must be 48 months in length. (Core)
I.	**Oversight**	**Section 1**	**Section 1: Oversight**
I.A.	**Sponsoring Institution** ***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.*** ***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.***	**[None]**	**Sponsoring Institution** ***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.*** ***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.***
I.A.1.	**The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**	**1.1.**	**The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**
I.B.	**Participating Sites** ***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.***	**[None]**	**Participating Sites** ***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.***
I.B.1.	**The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**	**1.2.**	**The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**
I.B.1.a)	Relation to Categorical Residencies	1.2.a.	Relation to Categorical Residencies The four-year combined training in internal medicine and pediatrics must be provided by ACGME-accredited categorical programs in these specialties that are sponsored by the same ACGME-accredited Sponsoring Institution and are in close geographic proximity. (Core)

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I.B.1.a).(1)	The four-year combined training in internal medicine and pediatrics must be provided by ACGME-accredited categorical programs in these specialties that are sponsored by the same ACGME-accredited Sponsoring Institution and are in close geographic proximity. (Core)	1.2.a.	Relation to Categorical Residencies The four-year combined training in internal medicine and pediatrics must be provided by ACGME-accredited categorical programs in these specialties that are sponsored by the same ACGME-accredited Sponsoring Institution and are in close geographic proximity. (Core)
I.B.1.a).(1).(a)	The one exception is when the pediatrics program is sponsored by a children's hospital, in which case either the designated institutional official (DIO) of the institution that sponsors the internal medicine residency program or the DIO of the institution that sponsors the pediatric residency program may have responsibility for oversight of the combined program. (Core)	1.2.a.1.	The one exception is when the pediatrics program is sponsored by a children's hospital, in which case either the designated institutional official (DIO) of the institution that sponsors the internal medicine residency program or the DIO of the institution that sponsors the pediatric residency program may have responsibility for oversight of the combined program. (Core)
I.B.1.a).(2)	The categorical programs must each participate in only one internal medicine-pediatrics program. (Core)	1.2.b.	The categorical programs must each participate in only one internal medicine-pediatrics program. (Core)
I.B.1.a).(3)	The residents in the categorical and combined programs must interact at all levels of training. (Core)	1.2.c.	The residents in the categorical and combined programs must interact at all levels of training. (Core)
I.B.1.a).(4)	The program directors of the related categorical programs and the program director(s) of the combined program must demonstrate collaboration and coordination of curriculum and rotations. (Core)	1.2.d.	The program directors of the related categorical programs and the program director(s) of the combined program must demonstrate collaboration and coordination of curriculum and rotations. (Core)
I.B.1.a).(4).(a)	To achieve appropriate coordination of the combined program and shared accountability, including integration of training and supervision in each discipline, the program directors of the categorical programs and the program director(s) of the combined program should hold at least quarterly meetings that involve consultation with faculty from both departments, as well as internal medicine-pediatrics residents and/or residents from both departments. (Detail)	1.2.d.1.	To achieve appropriate coordination of the combined program and shared accountability, including integration of training and supervision in each discipline, the program directors of the categorical programs and the program director(s) of the combined program should hold at least quarterly meetings that involve consultation with faculty from both departments, as well as internal medicine-pediatrics residents and/or residents from both departments. (Detail)
I.B.2.	**There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**	**1.3.**	**There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**
I.B.2.a)	**The PLA must:**	**[None]**	
I.B.2.a).(1)	**be renewed at least every 10 years; and, (Core)**	**1.3.a.**	**The PLA must be renewed at least every 10 years. (Core)**
I.B.2.a).(2)	**be approved by the designated institutional official (DIO). (Core)**	**1.3.b.**	**The PLA must be approved by the designated institutional official (DIO). (Core)**
I.B.3.	**The program must monitor the clinical learning and working environment at all participating sites. (Core)**	**1.4.**	**The program must monitor the clinical learning and working environment at all participating sites. (Core)**
I.B.3.a)	**At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)**	**1.5.**	**At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)**
I.B.4.	**The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)** **[The Review Committee may further specify]**	**1.6.**	**The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
I.C.	**Workforce Recruitment and Retention** **The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)**	**1.7.**	**Workforce Recruitment and Retention** **The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, 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)
I.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	Requirement Language
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, variety, and complexity in diagnoses and age, from infants to geriatric patients, sufficient for residents to achieve all of the required educational outcomes. (Core)
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 its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:**
I.D.2.a)	**access to food while on duty; (Core)**	**1.9.a.**	**access to food while on duty; (Core)**
I.D.2.b)	**safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)**	**1.9.b.**	**safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient 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 lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**
I.D.2.d)	**security and safety measures appropriate to the participating site; and, (Core)**	**1.9.d.**	**security and safety measures appropriate to the participating site; and, (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 disabilities consistent with the Sponsoring Institution's policy. (Core)**
I.D.3.	**Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**	**1.10.**	**Residents must have ready access to 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)**
I.E.	**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)**	**1.11.**	**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)**
II.	**Personnel**	**Section 2**	**Section 2: Personnel**
II.A.	**Program Director**	**2.1.**	**Program Director** **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)**
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 appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)**
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 must approve a change in program director and must verify the program director's licensure 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 retention of the program director for a length of time adequate to maintain continuity of leadership and 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)**	**2.4.**	**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)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.A.2.a)	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: (Core) Number of Approved Resident Positions:<7 | Minimum Support Required (FTE): 0.2 Number of Approved Resident Positions:7-10 | Minimum Support Required (FTE): 0.4 Number of Approved Resident Positions:>10 | Minimum Support Required (FTE): 0.5	2.4.a.	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: (Core) Number of Approved Resident Positions:<7 | Minimum Support Required (FTE): 0.2 Number of Approved Resident Positions:7-10 | Minimum Support Required (FTE): 0.4 Number of Approved Resident Positions:>10 | Minimum Support Required (FTE): 0.5
II.A.2.b)	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) Number of Approved Resident Positions:<15 | Minimum Aggregate APD Support Required (FTE): n/a Number of Approved Resident Positions:16-20 | Minimum Aggregate APD Support Required (FTE): 0.1 Number of Approved Resident Positions:21-25 | Minimum Aggregate APD Support Required (FTE): 0.2	2.4.b.	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) Number of Approved Resident Positions:<15 | Minimum Aggregate APD Support Required (FTE): n/a Number of Approved Resident Positions:16-20 | Minimum Aggregate APD Support Required (FTE): 0.1 Number of Approved Resident Positions:21-25 | Minimum Aggregate APD Support Required (FTE): 0.2

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.A.2.b) - (Continued)	Number of Approved Resident Positions:26-30 | Minimum Aggregate APD Support Required (FTE): 0.3 Number of Approved Resident Positions:31-35 | Minimum Aggregate APD Support Required (FTE): 0.4 Number of Approved Resident Positions:36-40 | Minimum Aggregate APD Support Required (FTE): 0.5 Number of Approved Resident Positions:41-45 | Minimum Aggregate APD Support Required (FTE): 0.6 Number of Approved Resident Positions:46-50 | Minimum Aggregate APD Support Required (FTE): 0.7 Number of Approved Resident Positions:51-55 | Minimum Aggregate APD Support Required (FTE): 0.8 Number of Approved Resident Positions:56-60 | Minimum Aggregate APD Support Required (FTE): 0.9 Number of Approved Resident Positions:61-65 | Minimum Aggregate APD Support Required (FTE): 1 Number of Approved Resident Positions:> 65 | Minimum Aggregate APD Support Required (FTE): 1.1	2.4.b. - (Continued)	Number of Approved Resident Positions:26-30 | Minimum Aggregate APD Support Required (FTE): 0.3 Number of Approved Resident Positions:31-35 | Minimum Aggregate APD Support Required (FTE): 0.4 Number of Approved Resident Positions:36-40 | Minimum Aggregate APD Support Required (FTE): 0.5 Number of Approved Resident Positions:41-45 | Minimum Aggregate APD Support Required (FTE): 0.6 Number of Approved Resident Positions:46-50 | Minimum Aggregate APD Support Required (FTE): 0.7 Number of Approved Resident Positions:51-55 | Minimum Aggregate APD Support Required (FTE): 0.8 Number of Approved Resident Positions:56-60 | Minimum Aggregate APD Support Required (FTE): 0.9 Number of Approved Resident Positions:61-65 | Minimum Aggregate APD Support Required (FTE): 1 Number of Approved Resident Positions:> 65 | Minimum Aggregate APD Support Required (FTE): 1.1
II.A.3.	**Qualifications of the program director:**	**2.5.**	**Qualifications of the Program Director** **The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (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 Director** **The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)**
II.A.3.b)	**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, (Core)**	**2.5.a.**	**The program director must possess 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. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.A.3.c)	must include ongoing clinical activity. (Core)	2.5.b.	The program director must demonstrate ongoing clinical activity. (Core)
II.A.4.	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)	2.6.	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (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 model of professionalism. (Core)
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 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)
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 administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains. (Core)
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 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)
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 authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)
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 accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)
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 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)
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 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)
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 the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 sign a non-competition guarantee 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 document verification of education for all residents within 30 days of completion of or departure from the 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 verification of an individual resident's education upon the resident's request, within 30 days. (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.l.**	**The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)**
II.B.	**Faculty** ***Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.*** ***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.***	**[None]**	**Faculty** ***Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.*** ***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.***
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 of faculty members with competence to instruct and supervise all residents. (Core)**
II.B.1.a)	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 settings. (Core)	2.7.a.	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 settings. (Core)
II.B.2.	**Faculty members must:**	**[None]**	
II.B.2.a)	**be role models of professionalism; (Core)**	**2.8.**	**Faculty Responsibilities** **Faculty members must be role models of professionalism. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.B.2.b)	**demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)**	**2.8.a.**	**Faculty members must demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care. (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 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)**
II.B.2.d)	**administer and maintain an educational environment conducive to educating residents; (Core)**	**2.8.c.**	**Faculty members must administer and maintain an educational environment conducive to educating residents. (Core)**
II.B.2.e)	**regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)**	**2.8.d.**	**Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)**
II.B.2.f)	**pursue faculty development designed to enhance their skills at least annually: (Core)**	**2.8.e.**	**Faculty members must pursue faculty development designed to enhance their skills at least annually: (Core)**
II.B.2.f).(1)	**as educators and evaluators; (Detail)**	**2.8.e.1.**	**as educators and evaluators; (Detail)**
II.B.2.f).(2)	**in quality improvement, eliminating health inequities, and patient safety; (Detail)**	**2.8.e.2.**	**in quality improvement, eliminating health inequities, and patient 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 residents' well-being; and, (Detail)**
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 practice-based learning and improvement efforts. (Detail)**
II.B.3.	**Faculty Qualifications**	**2.9.**	**Faculty Qualifications** **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**
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 qualifications in their field and hold appropriate institutional appointments. (Core)**
II.B.3.b)	**Physician faculty members must:**	**[None]**	
II.B.3.b).(1)	**have current certification in the specialty by the American Board of** 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)**	**2.10.**	**Physician faculty members must 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)**
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 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)**
II.B.4.a)	**Core faculty members must complete the annual ACGME Faculty Survey. (Core)**	**2.11.a.**	**Core faculty members must complete the annual ACGME Faculty 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, 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)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 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)
II.C.	**Program Coordinator**	**2.12.**	**Program Coordinator** **There must be a program coordinator. (Core)**
II.C.1.	**There must be a program coordinator. (Core)**	**2.12.**	**Program Coordinator** **There must be a program coordinator. (Core)**
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 provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**
II.C.2.a)	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: 0.2 Number of Approved Resident Positions:11-15 | Minimum FTE Required for Coordinator Support: 0.5 | Additional Aggregate FTE Required for Administration of the Program: 0.3 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 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 Number of Approved Resident Positions:26-30 | Minimum FTE Required for Coordinator Support: 0.5 | Additional Aggregate FTE Required for Administration of the Program: 0.6	2.12.b.	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: 0.2 Number of Approved Resident Positions:11-15 | Minimum FTE Required for Coordinator Support: 0.5 | Additional Aggregate FTE Required for Administration of the Program: 0.3 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 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 Number of Approved Resident Positions:26-30 | Minimum FTE Required for Coordinator Support: 0.5 | Additional Aggregate FTE Required for Administration of the Program: 0.6

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.C.2.a) - (Continued)	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: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: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: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: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: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
II.C.2.a) - (Continued)	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:> 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: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:> 65 | Minimum FTE Required for Coordinator Support: 0.5 | Additional Aggregate FTE Required for Administration of the Program: 1.4
II.D.	**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)**	**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.**	**graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)**
III.A.1.b).(1)	**holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)**	**3.2.b.**	**graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)**
III.A.1.b).(2)	**holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)**	**3.2.b.**	**graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 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)**
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 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)**
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 appoint more residents than approved 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 of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)**
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 combined residency program beyond the beginning of the PGY-2 level. (Core)
IV.	**Educational Program** ***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*** ***The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*** ***It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.***	**Section 4**	**Section 4: Educational Program** ***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*** ***The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*** ***It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.***
IV.A.	**Educational Components** **The curriculum must contain the following educational components:**	**4.2.**	**Educational Components** **The curriculum must contain the following educational components:**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (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 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)
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 responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured didactic activities; and, (Core)
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 protected time to participate in core 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 promote patient safety-related goals, tools, and techniques. (Core)
IV.B.	ACGME Competencies	[None]	ACGME Competencies *The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.*
IV.B.1.	The program must integrate the following ACGME Competencies into the curriculum:	[None]	The program must integrate all ACGME Competencies into the curriculum.
IV.B.1.a)	Professionalism Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)	4.3.	ACGME Competencies – Professionalism Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core) Residents must demonstrate competence in:
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	ACGME Competencies – Professionalism Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core) Residents must demonstrate competence in:
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)	4.3.a.	compassion, integrity, and respect for others; (Core)
IV.B.1.a).(1).(b)	responsiveness to patient needs that supersedes self-interest; (Core)	4.3.b.	responsiveness to patient needs that supersedes self-interest; (Core)
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 autonomy; (Core)
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)	4.3.e.	accountability to patients, society, and the profession; (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.B.1.a).(1).(f)	**respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)**	**4.3.f.**	**respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)**
IV.B.1.a).(1).(g)	**ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**	**4.3.g.**	**ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**
IV.B.1.a).(1).(h)	**appropriately disclosing and addressing conflict or duality of interest. (Core)**	**4.3.h.**	**appropriately disclosing and addressing conflict or duality of interest. (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 Care and Procedural Skills (Part A) 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)**
IV.B.1.b).(1).(a)	Residents must demonstrate the ability to:	4.4.a.	Residents must demonstrate the ability to:
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 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)
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, counseling, detection, and diagnosis and treatment of gender-specific diseases; (Core)
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 care settings, to include the inpatient ward, the critical care units, the emergency setting, and the ambulatory 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 of clinical disorders seen in the practice of general internal medicine and pediatrics in both inpatient and ambulatory settings; (Core)
IV.B.1.b).(1).(a).(v)	manage a sufficient number of undifferentiated acutely and severely ill patients; (Core)	4.4.a.5.	manage a sufficient number of undifferentiated acutely and severely ill 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 information about the patient; (Core)
IV.B.1.b).(1).(a).(vii)	organize and prioritize responsibilities to provide patient care that is safe, effective, and efficient; (Core)	4.4.a.7.	organize and prioritize responsibilities to provide patient care that is safe, 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 seamless transitions; (Core)
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 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)
IV.B.1.b).(1).(a).(x)	perform complete and accurate physical examinations; (Core)	4.4.a.10.	perform complete and accurate physical examinations; (Core)
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 therapeutic decisions that result in optimal 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 plans; (Core)
IV.B.1.b).(1).(a).(xiii)	provide effective health maintenance and anticipatory guidance; (Core)	4.4.a.13.	provide effective health maintenance and anticipatory guidance; (Core)
IV.B.1.b).(1).(a).(xiv)	provide appropriate role modeling; and, (Core)	4.4.a.14.	provide appropriate role modeling; and, (Core)
IV.B.1.b).(1).(a).(xv)	provide appropriate supervision. (Core)	4.4.a.15.	provide appropriate supervision. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 Care and Procedural Skills (Part B)** **Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (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 ability to manage patients using the laboratory and imaging techniques appropriately. (Core)
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 conditions with practices that are safe, scientifically based, effective, efficient, timely, and cost effective. (Core)
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 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)
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 procedural competence by performing the following procedures on pediatric patients: (Core)
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; (Core)
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; (Core)
IV.B.1.b).(2).(d).(vii)	peripheral intravenous catheter placement; (Core)	4.5.d.7.	peripheral intravenous catheter placement; (Core)
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, (Core)
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 maintain certification in Pediatric Advanced Life Support, including simulated placement of an intraosseous 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 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)**
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 knowledge of those areas appropriate for an internal medicine and pediatrics specialist, specifically: (Core)
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 disorders seen in the practices of general internal medicine and pediatrics; and, (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.B.1.c).(1).(b)	the core content of general internal medicine and pediatrics, including the subspecialties and relevant specialties outside of internal medicine and pediatrics. (Core)	4.6.2.	the core content of general internal medicine and pediatrics, including the subspecialties and relevant specialties outside of internal medicine and pediatrics. (Core)
IV.B.1.c).(2)	Residents must demonstrate sufficient knowledge:	4.6.b.	Residents must demonstrate sufficient knowledge:
IV.B.1.c).(2).(a)	to evaluate patients with an undiagnosed and undifferentiated presentation; (Core)	4.6.b.1.	to evaluate patients with an undiagnosed and undifferentiated 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 children and adults; (Core)
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 commonly used by general internists 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 management of emergency medical 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 diagnostic and therapeutic procedures. (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 sufficient knowledge of the basic and clinically supportive sciences appropriate to internal medicine and 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 understanding of the indications and contraindications for, and complications of the following pediatric 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-neonates; and, (Core)
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 simulated training when these procedures are important for a resident's post-residency career. (Detail)
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-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)**
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 competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise. (Core)**
IV.B.1.d).(1).(b)	**setting learning and improvement goals; (Core)**	**4.7.b.**	**Residents must demonstrate competence in setting learning and improvement goals. (Core)**
IV.B.1.d).(1).(c)	**identifying and performing appropriate learning activities; (Core)**	**4.7.c.**	**Residents must demonstrate competence in identifying and performing appropriate learning activities. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 competence in 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)**
IV.B.1.d).(1).(e)	**incorporating feedback and formative evaluation into daily practice; and, (Core)**	**4.7.e.**	**Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice. (Core)**
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 competence in locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)**
IV.B.1.d).(1).(g)	being an effective teacher; and, (Core)	4.7.g.	Residents must demonstrate competence in being an effective teacher. (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 competence in 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)
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 – 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)**
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 competence in 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)
IV.B.1.e).(1).(b)	**communicating effectively with physicians, other health professionals, and health-related agencies; (Core)**	**4.8.b.**	**Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-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 competence in working effectively as a member or leader of a health care team or other professional group. (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 competence in educating patients, patients' families, students, other residents, and other health 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 competence in acting in a consultative role to other physicians and health professionals. (Core)**
IV.B.1.e).(1).(f)	**maintaining comprehensive, timely, and legible health care records, if applicable; and, (Core)**	**4.8.f.**	**Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable. (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 insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.B.1.e).(2)	**Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**	**4.8.g.**	**Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**
IV.B.1.f)	**Systems-based Practice** **Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)**	**4.9.**	**ACGME Competencies - Systems-Based Practice** **Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)**
IV.B.1.f).(1)	**Residents must demonstrate competence in:**	**[None]**	
IV.B.1.f).(1).(a)	**working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)**	**4.9.a.**	**Residents must demonstrate competence in working effectively in various health care delivery settings and systems relevant to their clinical specialty. (Core)**
IV.B.1.f).(1).(b)	**coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)**	**4.9.b.**	**Residents must demonstrate competence in coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty. (Core)**
IV.B.1.f).(1).(c)	**advocating for quality patient care and optimal patient care systems; (Core)**	**4.9.c.**	**Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems. (Core)**
IV.B.1.f).(1).(d)	**participating in identifying system errors and implementing potential systems solutions; (Core)**	**4.9.d.**	**Residents must demonstrate competence in participating in identifying system errors and implementing potential systems solutions. (Core)**
IV.B.1.f).(1).(e)	**incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; (Core)**	**4.9.e.**	**Residents must demonstrate competence in incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate. (Core)**
IV.B.1.f).(1).(f)	**understanding health care finances and its impact on individual patients' health decisions; and, (Core)**	**4.9.f.**	**Residents must demonstrate competence in understanding health care finances and its impact on individual patients' health decisions. (Core)**
IV.B.1.f).(1).(g)	**using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)**	**4.9.g.**	**Residents must demonstrate competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)**
IV.B.1.f).(1).(h)	working in teams and effectively transmitting necessary clinical information to ensure safe and proper care of patients including the transition of care between settings; and, (Core)	4.9.i.	Residents must demonstrate competence in working in teams and effectively transmitting necessary clinical information to ensure safe and proper care of patients including the transition of care between settings. (Core)
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 competence in advocating for the promotion of health and the prevention of disease and injury in populations. (Core)
IV.B.1.f).(2)	**Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)**	**4.9.h.**	**Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.C.	**Curriculum Organization and Resident Experiences**	**4.10. - 4.12.**	**Curriculum Organization and Resident Experiences** **4.10. Curriculum Structure** **The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)** **4.11. Didactic and Clinical Experiences** **Residents must be provided with protected time to participate in core didactic activities. (Core)** **4.12. Pain Management** **The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**
IV.C.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 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)**
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 schedules for ambulatory training that minimize conflicting inpatient and outpatient responsibilities. (Detail)
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 instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**
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 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)
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 resident an opportunity to review all of the 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 lectures, web-based content, pod 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 to participate in morning report, grand rounds, journal club, and morbidity and mortality (or quality improvement) conferences that also involve faculty. (Detail)
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 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)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 opportunities for residents to have peer-peer 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 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)
IV.C.5.	Curriculum	4.11.c.	Curriculum 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)
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 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)
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 cohesive planned educational experience, and not simply be a series of rotations between the two specialties. (Core)
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 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)
IV.C.5.d)	Residents must have graded responsibility for patient care and teaching. (Core)	4.11.c.3.	Residents must have graded responsibility for patient care and teaching. (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 each specialty. (Core)
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 in clinical rotations and other 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 formal goals, objectives, and a specific 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 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)
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 specialty or the other should be for periods of at least one rotation and not more than six rotations. (Detail)
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 exposure, unnecessary duplication of educational experiences should be avoided. (Detail)
IV.C.6.	Continuity Clinics	4.11.d.	Continuity Clinics The longitudinal continuity experience must allow residents to develop a continuous, long-term therapeutic relationship with a panel of general medicine and pediatric patients. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.C.6.a)	The longitudinal continuity experience must allow residents to develop a continuous, long-term therapeutic relationship with a panel of general medicine and pediatric patients. (Core)	4.11.d.	Continuity Clinics The longitudinal continuity experience must allow residents to develop a continuous, long-term therapeutic relationship with a panel of general 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 ensure a minimum of 36 half-day sessions per year of a longitudinal outpatient experience. (Core)
IV.C.6.b).(1)	The sessions must be scheduled over a minimum of 26 weeks per year. (Core)	4.11.d.1.a.	The sessions must be scheduled over a minimum of 26 weeks per year. (Core)
IV.C.6.b).(2)	Continuity clinic experience should be obtained either by a combined internal medicine-pediatrics continuity clinic or by alternating internal medicine and pediatrics continuity clinics. (Detail)	4.11.d.1.b.	Continuity clinic experience should be obtained either by a combined internal medicine-pediatrics continuity clinic or by alternating internal medicine and pediatrics continuity clinics. (Detail)
IV.C.6.b).(3)	Each resident’s longitudinal continuity experience:	[None]	
IV.C.6.b).(3).(a)	should include the resident serving as the primary physician in a medical home model for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients; (Detail)	4.11.d.2.	Each resident should serve as the primary physician in a medical home model for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients. (Detail)
IV.C.6.b).(3).(b)	should include evaluation of performance data for each resident’s continuity panel of patients relating to both chronic disease management and preventive health care; (Detail)	4.11.d.3.	Evaluation of performance data should be provided for each resident’s continuity panel of patients relating to both chronic disease management and preventive health care. (Detail)
IV.C.6.b).(3).(c)	should include faculty guidance for developing a data-based action plan that is evaluated at least twice a year; (Detail)	4.11.d.4.	Faculty guidance should be provided for developing a data-based action plan that is evaluated at least twice a year. (Detail)
IV.C.6.b).(3).(d)	should include resident participation in coordination of care across health care settings; (Detail)	4.11.d.5.	Residents should participate in coordination of care across health care settings. (Detail)
IV.C.6.b).(3).(d).(i)	Residents should be available to participate in the management of their continuity panel of patients between outpatient visits. (Detail)	4.11.d.5.a.	Residents should be available to participate in the management of their continuity panel of patients between outpatient visits. (Detail)
IV.C.6.b).(3).(d).(ii)	There should be systems of care to provide coverage of urgent problems when a resident is not readily available. (Detail)	4.11.d.5.b.	There should be systems of care to provide coverage of urgent problems when a resident is not readily available. (Detail)
IV.C.6.b).(3).(e)	must include supervision by faculty who develop a longitudinal relationship with residents throughout the duration of their continuity experience; (Core)	4.11.d.6.	There must be supervision by faculty who develop a longitudinal relationship with residents throughout the duration of their continuity 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 faculty preceptors should not 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 supervision and teaching. (Core)
IV.C.6.b).(3).(g).(i)	Faculty should not have other patient care duties while supervising more than two residents or other learners. (Detail)	4.11.d.8.a.	Faculty should not have other patient care duties while supervising more than two residents or other learners. (Detail)
IV.C.6.b).(3).(g).(ii)	Other faculty responsibilities should not detract from the supervision and teaching of residents. (Detail)	4.11.d.8.b.	Other faculty responsibilities should not detract from the supervision and teaching of residents. (Detail)
IV.C.6.b).(3).(g).(iii)	Faculty should have expertise in primary care and the principles of the medical home. (Detail)	4.11.d.8.c.	Faculty should have expertise in primary care and the principles of the medical home. (Detail)
IV.C.6.b).(4)	There must be an adequate volume of patients to ensure exposure to the spectrum of normal development at all age levels, as well as the longitudinal management of children and adults with special health care needs and chronic conditions. (Core)	4.11.d.9.	There must be an adequate volume of patients to ensure exposure to the spectrum of normal development at all age levels, as well as the longitudinal management of children and adults with special health care needs and chronic conditions. (Core)
IV.C.6.b).(5)	There must be an even distribution of pediatric and adult patients, whether the experience occurs in combined or alternating separate clinic settings. (Core)	4.11.d.10.	There must be an even distribution of pediatric and adult patients, whether the experience occurs in combined or alternating separate clinic settings. (Core)

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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]	

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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 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)
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 assigned more than eight new patients in 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 responsible for the ongoing care of more 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-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)
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 resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients.(Core)
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-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 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 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)
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 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 on inpatient medicine rotations. (Core)
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 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 on inpatient 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 must be limited to patients on inpatient medicine rotations 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)
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 rotations must not be required to relate to an excessive number of attending physicians. (Core)
IV.C.8.c).(3).(l)	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 inpatient medicine rotations must not supervise internal medicine-pediatrics residents on any internal medicine or pediatrics inpatient rotation. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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.	The training in internal medicine for the combined program must include care of adults with various illnesses in critical care units (e.g., intensive care units, cardiac care units, respiratory care units). (Core)
IV.C.8.d).(1)	Patient care experiences in the critical care units should occur during the first or second year and again in subsequent years. (Detail)	4.11.f.5.a.	Patient care experiences in the critical care units should occur during the first or second year and again in subsequent years. (Detail)
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 combined program must include subspecialty experience, including exposure to neurology, that is inpatient, outpatient, or a combination of the two settings. (Core)
IV.C.8.e).(1)	Residents should have at least four months of subspecialty experiences. (Detail)	4.11.f.6.a.	Residents should have at least four months of subspecialty experiences. (Detail)
IV.C.8.e).(2)	This experience should include serving as a consultant. (Detail)	4.11.f.6.b.	This experience should include serving as a consultant. (Detail)
IV.C.8.f)	clinical experience in geriatrics; (Core)	4.11.f.7.	The training in internal medicine for the combined program must include 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 geriatrics rotation. (Detail)
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 the combined program must include 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. (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 the combined program must include required transplant rotations in dedicated units not to exceed one month in four years. (Detail)
IV.C.9.	Pediatrics Component	4.11.g.	Pediatrics Component A pediatric educational unit must be a block (four weeks or one month) or 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 block (four weeks or one month) or 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 unit should be a minimum of 32 half-day sessions. A longitudinal inpatient educational unit should be a minimum of 200 hours. (Detail)
IV.C.9.b)	The pediatrics curriculum must include:	4.11.g.2.	The pediatrics curriculum must include a minimum of nine educational units of inpatient care experiences, including: (Core)
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 a minimum of nine educational units of inpatient care experiences, including: (Core)
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. (Detail)
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. (Detail)
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. (Detail)
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. (Detail)
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 a minimum of six educational units of additional subspecialty experiences, including: (Core)
IV.C.9.b).(2).(a)	developmental-behavioral pediatrics; (Core)	4.11.3.a.	developmental-behavioral pediatrics; (Core)
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. (Detail)

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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)
IV.C.9.b).(2).(c)	four educational units of four of the following subspecialties: (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)
IV.C.9.b).(2).(c).(i)	child abuse; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)

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IV.C.9.b).(2).(c).(ii)	medical genetics; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)
IV.C.9.b).(2).(c).(iii)	pediatric allergy and immunology; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)
IV.C.9.b).(2).(c).(iv)	pediatric cardiology; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)

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IV.C.9.b).(2).(c).(v)	pediatric dermatology; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)
IV.C.9.b).(2).(c).(vi)	pediatric endocrinology; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)
IV.C.9.b).(2).(c).(vii)	pediatric gastroenterology; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)

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IV.C.9.b).(2).(c).(viii)	pediatric hematology-oncology; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)
IV.C.9.b).(2).(c).(ix)	pediatric infectious diseases; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)
IV.C.9.b).(2).(c).(x)	pediatric nephrology; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)

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IV.C.9.b).(2).(c).(xi)	pediatric neurology; (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)
IV.C.9.b).(2).(c).(xii)	pediatric pulmonology; or, (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)
IV.C.9.b).(2).(c).(xiii)	pediatric rheumatology. (Core)	4.11.3.c.	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) • pediatric rheumatology. (Core)

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IV.C.9.b).(3)	a minimum of four educational units of ambulatory experiences, including: (Core)	4.11.4.	The pediatrics curriculum must include a minimum of four educational units of ambulatory experiences, including: (Core)
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 medicine (one educational unit of emergency medicine is equivalent to 160 hours); and, (Detail)
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 evaluation of pediatric patients in the 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 experiences, to include elements of community pediatrics and child advocacy. (Detail)
IV.C.9.b).(4)	two educational units as an individualized curriculum. (Core)	4.11.g.5.	The pediatrics curriculum must include: two educational units as an 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 determined by the learning needs and career plans of the resident and should be developed through the 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 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.***
IV.D.1.	**Program Responsibilities**	**4.13.**	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**
IV.D.1.a)	**The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**	**4.13.**	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**
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 Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)**
IV.D.1.c)	**The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)**	**4.13.b.**	**The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.D.2.	Faculty Scholarly Activity	4.14.	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-analyses, review articles, chapters in medical textbooks, or case reports • Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials • Contribution to professional committees, educational organizations, or editorial boards • Innovations in education
IV.D.2.a)	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-analyses, review articles, chapters in medical textbooks, or case reports • Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials • Contribution to professional committees, educational organizations, or editorial boards • Innovations in education	4.14.	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-analyses, review articles, chapters in medical textbooks, or case reports • Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials • Contribution to professional committees, educational organizations, or editorial boards • Innovations in education
IV.D.2.b)	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:	4.14.a.	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods: • 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) • peer-reviewed publication. (Outcome)

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)**	**4.14.a.**	**The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:** **• 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)** **• peer-reviewed publication. (Outcome)**
IV.D.2.b).(2)	**peer-reviewed publication. (Outcome)**	**4.14.a.**	**The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:** **• 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)** **• peer-reviewed publication. (Outcome)**
IV.D.3.	**Resident Scholarly Activity**	**4.15.**	**Resident Scholarly Activity** **Residents must participate in scholarship. (Core)**
IV.D.3.a)	**Residents must participate in scholarship. (Core)**	**4.15.**	**Resident Scholarly Activity** **Residents must participate in scholarship. (Core)**
V.	**Evaluation**	**Section 5**	**Section 5: Evaluation**
V.A.	**Resident Evaluation**	**5.1.**	**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**	**5.1.**	**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 educational assignment. (Core)**	**5.1.**	**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)	5.1.i.	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 Language
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 patients and families on the broad range 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 diagnostic and therapeutic decisions based on best evidence and to develop and carry out management plans. (Detail)
V.A.1.b)	**Evaluation must be documented at the completion of the assignment. (Core)**	**5.1.a.**	**Evaluation must be documented at the completion of the assignment. (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 three months in duration, evaluation must be documented at least every three months. (Core)**
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 continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three 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 objective performance evaluation based on the Competencies and the specialty-specific Milestones.** (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 evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)**
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' communication skills and professionalism should include evaluations by patients and/or patients' families. (Detail)
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 information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)**
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 observation of resident-patient 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 validated formative assessment method (e.g., in-training examination, chart stimulated recall). (Detail)
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 method should be administered annually 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 designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones. (Core)**
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 designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and 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 designee, with input from the Clinical Competency Committee, must create and document an individualized 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 to assist residents in this process, including: (Detail)
V.A.1.d).(2).(a).(i).(a)	faculty mentorship to help residents create learning goals; and, (Detail)	5.1.d.2.a.	faculty mentorship to help residents create learning goals; and, (Detail)
V.A.1.d).(2).(a).(i).(b)	systems for tracking and monitoring progress toward completing the individualized learning plan. (Detail)	5.1.d.2.b.	systems for tracking and monitoring progress toward completing the individualized learning plan. (Detail)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
V.A.1.d).(3)	**develop plans for residents failing to progress, following institutional policies and procedures. (Core)**	**5.1.e.**	**The program director or their designee, with input from the Clinical Competency Committee, must develop plans for residents failing to progress, 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)**	**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)
V.A.2.	**Final Evaluation**	**5.2.**	**Resident Evaluation: Final Evaluation** **The program director must provide a final evaluation for each resident upon completion of the program. (Core)**
V.A.2.a)	**The program director must provide a final evaluation for each resident upon completion of the program. (Core)**	**5.2.**	**Resident Evaluation: Final Evaluation** **The program director must provide a 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	Requirement Language
V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)	5.3.c.	The Clinical Competency Committee must review all resident evaluations at least semi-annually. (Core)
V.A.3.b).(2)	determine each resident's progress on achievement of the specialty-specific Milestones; and, (Core)	5.3.d.	The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones. (Core)
V.A.3.b).(3)	meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)	5.3.e.	The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)
V.B.	Faculty Evaluation	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)
V.B.1.	The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)
V.B.1.a)	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)	5.4.a.	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)
V.B.1.b)	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)	5.4.b.	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)
V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feedback on their evaluations at least annually. (Core)
V.B.3.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)	5.4.d.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)
V.C.	Program Evaluation and Improvement	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1.	The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1.a)	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)	5.5.a.	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
V.C.1.b).(1)	review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core)
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
V.C.1.b).(3)	review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)
V.C.1.c)	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)	5.5.e.	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)
V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)	5.5.f.	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)
V.C.1.e)	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)	5.5.g.	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)
V.C.2.	The program must complete a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must complete a Self-Study and submit it to the DIO. (Core)
V.C.3.	*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 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.*
V.C.3.a)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.	Board Certification For specialties in which the ABMS 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)
V.C.3.b)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.a.	For specialties in which the ABMS 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)
V.C.3.c)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.b.	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
V.C.3.d)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.c.	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
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 5.6.a.-c., 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)
V.C.3.f)	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)	5.6.e.	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)
VI.	The Learning and Working Environment *Residency education must occur in the context of a learning and working environment that emphasizes the following principles:* *• Excellence in the safety and quality of care rendered to patients by residents today* *• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice* *• Excellence in professionalism* *• Appreciation for the privilege of caring for patients* *• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*	Section 6	Section 6: The Learning and Working Environment The Learning and Working Environment *Residency education must occur in the context of a learning and working environment that emphasizes the following principles:* *• Excellence in the safety and quality of care rendered to patients by residents today* *• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice* *• Excellence in professionalism* *• Appreciation for the privilege of caring for patients* *• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*
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 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.*
VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)	6.1.	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.A.1.a).(2)	**Patient Safety Events** ***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***	[None]	**Patient Safety Events** ***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***
VI.A.1.a).(2).(a)	**Residents, fellows, faculty members, and other clinical staff members 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 members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report 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 members, and other clinical staff members must be provided with summary information of their institution's patient safety reports.** (Core)
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 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)**
VI.A.1.a).(3)	**Quality Metrics** ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***	[None]	**Quality Metrics** ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***
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 must receive data on quality metrics and benchmarks related to their patient populations. (Core)**
VI.A.2.	**Supervision and Accountability**	[None]	**Supervision and Accountability** ***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 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.***

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.A.2.a)	***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 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 and Accountability** ***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 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.***
VI.A.2.a).(1)	**Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)**	6.5.	**Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (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 must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (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 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)**
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 supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.***
VI.A.2.b).(1)	**Direct Supervision:**	6.7.	**Direct Supervision** ***The supervising physician is physically present with the resident during the key portions of the patient interaction.*** ***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.***

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.A.2.b).(1).(a)	the supervising physician is physically present with the resident during the key portions of the patient interaction; or,	6.7.	Direct Supervision *The supervising physician is physically present with the resident during the key portions of the patient interaction.* *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)
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.	Direct Supervision *The supervising physician is physically present with the resident during the key portions of the patient interaction.* *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 Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.A.2.e).(1)	Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)	6.10.a.	Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)
VI.A.2.f)	Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)	6.11.	Faculty supervision assignments 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)
VI.B.	Professionalism	6.12.	Professionalism 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)
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 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)
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 program must be accomplished without excessive reliance on residents to fulfill non-physician obligations. (Core)
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the program must ensure manageable 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 program must 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)
VI.B.3.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)	6.12.d.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety 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 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)
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 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)
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 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)

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

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

Roman Numeral Requirement Number	Requirement Language	Reformatted 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). At-home 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 Requirement Number	Requirement Language	Reformatted 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)**	**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)**
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)**
VI.F.4.c)	**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 week.	**6.24.**	**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 week.
VI.F.5.	**Moonlighting**	**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.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 Language
VI.F.8.	At-Home Call	6.28.	At-Home Call 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)
VI.F.8.a)	Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)	6.28.	At-Home Call Time spent on patient care activities 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)
VI.F.8.a).(1)	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)	6.28.a.	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)