Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requiremen
	Definition of Graduate Medical Education		Definition of Graduate Medical Educa
	Graduate medical education is the crucial step of professional		Graduate medical education is the cr
	development between medical school and autonomous clinical practice. It		development between medical schoo
	is in this vital phase of the continuum of medical education that residents		is in this vital phase of the continuun
	learn to provide optimal patient care under the supervision of faculty		learn to provide optimal patient care
	members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.		members who not only instruct, but s compassion, cultural sensitivity, prot
	Graduate medical education transforms medical students into physician		Graduate medical education transfor
	scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and		scholars who care for the patient, pat community; create and integrate new
	educate future generations of physicians to serve the public. Practice		educate future generations of physic
	patterns established during graduate medical education persist many		patterns established during graduate
Int.A.	years later.	[None]	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 responsibility for patient care. The ca appropriate faculty supervision and o residents to attain the knowledge, sk empathy required for autonomous pr develops physicians who focus on ex- equitable, affordable, quality care; an serve. Graduate medical education va group of physicians brings to medical inclusive and psychologically safe lea Graduate medical education occurs if foundation for practice-based and life development of the physician, begun through faculty modeling of the effac environment that emphasizes joy in o rigor, and discovery. This transforma and intellectually demanding and occ environments committed to graduate being of patients, residents, fellows, members of the health care team.
	<b>Definition of Specialty</b> Urology evaluates and treats patients with disorders of the genitourinary tract, including the adrenal gland and external genitalia. Specialists in this discipline demonstrate knowledge of the basic and clinical sciences related to the normal and diseased genitourinary system, as well as attendant skills in medical and surgical therapy. Residency programs educate physicians in the prevention and treatment of genitourinary disease, including the diagnosis, medical, and surgical management, and reconstruction of the genitourinary tract.	[None]	<b>Definition of Specialty</b> Urology evaluates and treats patients w including the adrenal gland and externa demonstrate knowledge of the basic and and diseased genitourinary system, as w surgical therapy. Residency programs e treatment of genitourinary disease, inclu surgical management, and reconstruction

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

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

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

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

with disorders of the genitourinary tract, nal genitalia. Specialists in this discipline and clinical sciences related to the normal s well as attendant skills in medical and educate physicians in the prevention and cluding the diagnosis, medical, and tion of the genitourinary tract.

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremer
Requirement Number	Length of Educational Program	Requirement Number	Kequiremen
			Length of Program
Int.C.	The educational program in urology must be 60 months in length. (Core)	4.1.	The educational program in urology mu
l.	Oversight	Section 1	Section 1: Oversight
	Sponsoring Institution The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.		Sponsoring Institution The Sponsoring Institution is the org ultimate financial and academic resp medical education, consistent with th Requirements.
I.A.	When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.	[None]	When the Sponsoring Institution is n most commonly utilized site of clinic primary clinical site.
	The program must be sponsored by one ACGME-accredited Sponsoring	F	The program must be sponsored by
I.A.1.	Institution. (Core)	1.1.	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 or educational assignments/rotations
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 Sp primary clinical site. (Core)
I.B.1.a)	To provide an adequate interdisciplinary educational experience, the primary clinical site must participate in an ACGME-accredited general surgery program through the same Sponsoring Institution as the urology program, unless an exception is granted by the Review Committee. (Core)	1.2.a.	To provide an adequate interdisciplinary clinical site must participate in an ACGM through the same Sponsoring Institution exception is granted by the Review Cor
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 ag and each participating site that gove program and the participating site pr
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 ev
I.B.2.a).(2)	be approved by the designated institutional official (DIO). (Core)	1.3.b.	The PLA must be approved by the de (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 clinic 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 by the program director as the site d resident education at that site, in col (Core)
I.B.4.	The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)	1.6.	The program director must submit an participating sites routinely providing for all residents, of one month full tin the ACGME's Accreditation Data Sys
I.B.5.	Addition of participating sites for required rotations must be based on sound educational rationale and approved by the Review Committee. (Core)	1.6.a.	Addition of participating sites for require educational rationale and approved by t

nust be 60 months in length. (Core)

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

not a rotation site for the program, the inclusion in the inclusion is the inclusion in the program is the

y one ACGME-accredited Sponsoring

ion providing educational experiences ons for residents.

Sponsoring Institution, must designate a

ary educational experience, the primary GME-accredited general surgery program ion as the urology program, unless an committee. (Core)

agreement (PLA) between the program verns the relationship between the providing a required assignment. (Core)

every 10 years. (Core) designated institutional official (DIO).

ical learning and working environment

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

any additions or deletions of ing an educational experience, required time equivalent (FTE) or more through ystem (ADS). (Core)

ired rotations must be based on sound y the Review Committee. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Boguiromon
Requirement Number	Assignments to distant sites must be based on the educational resources that		<b>Requiremen</b> Assignments to distant sites must be ba
	are not available at the primary clinical site or at a nearby participating site.		are not available at the primary clinical s
I.B.5.a)	(Core)	1.6.a.1.	(Core)
	Workforce Recruitment and Retention		Workforce Recruitment and Retention
	The program, in partnership with its Sponsoring Institution, must engage		The program, in partnership with its \$
	in practices that focus on mission-driven, ongoing, systematic recruitment		in practices that focus on mission-dr
	and retention of a diverse and inclusive workforce of residents, fellows (if		and retention of a diverse and inclusi
	present), faculty members, senior administrative GME staff members, and		present), faculty members, senior ad
I.C.	other relevant members of its academic community. (Core)	1.7.	other relevant members of its acaden
			Resources
			The program, in partnership with its \$
I.D.	Resources	1.8.	the availability of adequate resources
			Resources
	The program, in partnership with its Sponsoring Institution, must ensure	4.0	The program, in partnership with its s
I.D.1.	the availability of adequate resources for resident education. (Core)	1.8.	the availability of adequate resources
	There must be adequate space and equipment for the educational program,		There must be adequate space and equ
	including meeting rooms and classrooms with audiovisual and other educational aids; appropriate office space for residents; diagnostic, therapeutic, and		including meeting rooms and classroom aids; appropriate office space for reside
	research facilities; and outpatient facilities, clinic, and office space accessible to		research facilities; and outpatient facilitie
I.D.1.a)	residents for pre-operative evaluation and post-operative follow-up. (Core)	1.8.a.	residents for pre-operative evaluation ar
	Clinical facilities must contain state-of-the-art equipment to perform diagnostic	1.0.0.	Clinical facilities must contain state-of-th
I.D.1.b)	and therapeutic procedures. (Core)	1.8.b.	and therapeutic procedures. (Core)
,	Equipment to perform the following procedures must be available: flexible		Equipment to perform the following proc
	cystoscopy; ureteroscopy; percutaneous endoscopy; percutaneous renal		cystoscopy; ureteroscopy; percutaneous
	access; ultrasonography and biopsy; fluoroscopy; laparoscopy; laser therapy;		access; ultrasonography and biopsy; flu
I.D.1.b).(1)	and renal and prostate ultrasound. (Core)	1.8.b.1.	and renal and prostate ultrasound. (Core
I.D.1.b).(2)	Urodynamic equipment must be present at a minimum of one site. (Core)	1.8.b.2.	Urodynamic equipment must be present
	Video imaging must be available to allow adequate supervision and education		Video imaging must be available to allow
I.D.1.b).(3)	during endoscopic procedures. (Core)	1.8.b.3.	during endoscopic procedures. (Core)
	A sufficient number and variety of inpatient and ambulatory adult and pediatric		A sufficient number and variety of inpation
I.D.1.c)	patients with urologic disease must be available for resident education. (Core)	1.8.c.	patients with urologic disease must be a
	The program, in partnership with its Sponsoring Institution, must ensure		The program, in partnership with its \$
	healthy and safe learning and working environments that promote resident	4.0	healthy and safe learning and workin
I.D.2.		1.9.	resident well-being and provide for:
I.D.2.a)	access to food while on duty; (Core) safe, quiet, clean, and private sleep/rest facilities available and accessible	1.9.a.	access to food while on duty; (Core) safe, guiet, clean, and private sleep/re
I.D.2.b)		1.9.b.	for residents with proximity appropria
	clean and private facilities for lactation that have refrigeration capabilities,		clean and private facilities for lactatic
I.D.2.c)		1.9.c.	with proximity appropriate for safe pa
·,	security and safety measures appropriate to the participating site; and,		security and safety measures approp
I.D.2.d)	(Core)	1.9.d.	(Core)
	accommodations for residents with disabilities consistent with the		accommodations for residents with d
I.D.2.e)	Sponsoring Institution's policy. (Core)	1.9.e.	Sponsoring Institution's policy. (Core

based on the educational resources that I site or at a nearby participating site.

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

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

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

quipment for the educational program, ms with audiovisual and other educational lents; diagnostic, therapeutic, and ities, clinic, and office space accessible to and post-operative follow-up. (Core)

-the-art equipment to perform diagnostic

ocedures must be available: flexible bus endoscopy; percutaneous renal fluoroscopy; laparoscopy; laser therapy; ore)

ent at a minimum of one site. (Core)

ow adequate supervision and education

atient and ambulatory adult and pediatric available for resident education. (Core)

s Sponsoring Institution, must ensure ing environments that promote

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

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

opriate to the participating site; and,

disabilities consistent with the re)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
I.D.3.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)	1.10.	Residents must have ready access to appropriate reference material in prir include access to electronic medical capabilities. (Core)
16	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	1.11.	Other Learners and Health Care Pers The presence of other learners and o but not limited to residents from othe and advanced practice providers, mu
I.E. II.	residents' education. (Core) Personnel	Section 2	appointed residents' education. (Cor Section 2: Personnel
II.A.	Program Director	2.1.	Program Director There must be one faculty member a authority and accountability for the o with all applicable program requirem
II.A.1.		2.1.	Program Director There must be one faculty member a authority and accountability for the o with all applicable program requirem
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 r director and must verify the program appointment. (Core)
II.A.1.a).(1)	Final approval of the program director resides with the Review Committee. (Core)	2.2.a.	Final approval of the program directo (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 reter length of time adequate to maintain c stability. (Core)
II.A.2.	The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)	2.4.	The program director and, as applica must be provided with support adequ based upon its size and configuration
II.A.2.a)	At a minimum, the program director must be provided with support equal to a dedicated minimum of 0.2 FTE for administration of the program. (Core)	2.4.a.	At a minimum, the program director must dedicated minimum of 0.2 FTE for admited matrix and the set of th
II.A.3.	Qualifications of the program director:	2.5.	Qualifications of the Program Director The program director must possess years of documented educational and qualifications acceptable to the Revie
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 years of documented educational and qualifications acceptable to the Revie
II.A.3.b)	must include current certification in the specialty for which they are the program director by the American Board of Urology or by the American Osteopathic Board of Surgery, or specialty qualifications that are acceptable to the Review Committee; and, (Core)	2.5.a.	The program director must possess for which they are the program direct or by the American Osteopathic Boar qualifications that are acceptable to t
II.A.3.c)	must include ongoing clinical activity. (Core)	2.5.b.	The program director must demonstr
II.A.3.d)	should include scholarly activity. (Core)	2.5.c.	The program director should demonstra

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

rsonnel

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

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

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

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

tor resides with the Review Committee.

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

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

nust be provided with support equal to a ministration of the program. (Core)

tor

s specialty expertise and at least three nd/or administrative experience, or view Committee. (Core)

tor

s specialty expertise and at least three and/or administrative experience, or view Committee. (Core)

s current certification in the specialty ector by the American Board of Urology pard of Surgery, or specialty the Review Committee. (Core) strate ongoing clinical activity. (Core)

rate scholarly activity. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Boguiromont
Requirement Number			Requirement
	Program Director Responsibilities		Program Director Responsibilities
	The program director must have responsibility, authority, and		The program director must have resp
	accountability for: administration and operations; teaching and scholarly		accountability for: administration and
	activity; resident recruitment and selection, evaluation, and promotion of		activity; resident recruitment and sele
	residents, and disciplinary action; supervision of residents; and resident		residents, and disciplinary action; su
II.A.4.	education in the context of patient care. (Core)	2.6.	education in the context of patient car
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 n
	design and conduct the program in a fashion consistent with the needs of		The program director must design and
	the community, the mission(s) of the Sponsoring Institution, and the		consistent with the needs of the com
II.A.4.a).(2)	mission(s) of the program; (Core)	2.6.b.	Sponsoring Institution, and the mission
			The program director must administe
	administer and maintain a learning environment conducive to educating	260	environment conducive to educating t
II.A.4.a).(3)	the residents in each of the ACGME Competency domains; (Core)	2.6.c.	Competency domains. (Core)
			The program director must have the a
	have the authority to approve or remove physicians and non-physicians as		physicians and non-physicians as fac
	faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate		sites, including the designation of con develop and oversee a process to eva
II.A.4.a).(4)	candidates prior to approval; (Core)	2.6.d.	(Core)
	have the authority to remove residents from supervising interactions		The program director must have the a
	and/or learning environments that do not meet the standards of the		supervising interactions and/or learni
II.A.4.a).(5)	program; (Core)	2.6.e.	the standards of the program. (Core)
	submit accurate and complete information required and requested by the		The program director must submit ac
II.A.4.a).(6)	DIO, GMEC, and ACGME; (Core)	2.6.f.	required and requested by the DIO, G
	provide a learning and working environment in which residents have the		The program director must provide a
	opportunity to raise concerns, report mistreatment, and provide feedback		which residents have the opportunity
	in a confidential manner as appropriate, without fear of intimidation or		mistreatment, and provide feedback in
II.A.4.a).(7)		2.6.g.	appropriate, without fear of intimidation
	ensure the program's compliance with the Sponsoring Institution's		The program director must ensure the
	policies and procedures related to grievances and due process, including		Sponsoring Institution's policies and
	when action is taken to suspend or dismiss, or not to promote or renew	2 C h	and due process, including when acti
II.A.4.a).(8)	the appointment of a resident; (Core)	2.6.h.	not to promote or renew the appointm
	ensure the program's compliance with the Sponsoring Institution's		The program director must ensure the Sponsoring Institution's policies and
II.A.4.a).(9)	policies and procedures on employment and non-discrimination; (Core)	2.6.i.	discrimination. (Core)
	Residents must not be required to sign a non-competition guarantee or		Residents must not be required to sig
II.A.4.a).(9).(a)	restrictive covenant. (Core)	3.1.	restrictive covenant. (Core)
1 1 1 1			The program director must document
	document verification of education for all residents within 30 days of		residents within 30 days of completio
II.A.4.a).(10)	completion of or departure from the program; and, (Core)	2.6.j.	(Core)
	provide verification of an individual resident's education upon the		The program director must provide ve
II.A.4.a).(11)	resident's request, within 30 days; and (Core)	2.6.k.	education upon the resident's reques
	provide applicants who are offered an interview with information related to		The program director must provide ap
	the applicant's eligibility for the relevant specialty board examination(s).		interview with information related to t
II.A.4.a).(12)	(Core)	2.6.I.	relevant specialty board examination(

sponsibility, authority, and nd operations; teaching and scholarly election, evaluation, and promotion of supervision of residents; and resident care. (Core)

e model of professionalism. (Core) and conduct the program in a fashion mmunity, the mission(s) of the sion(s) of the program. (Core) ster and maintain a learning

g the residents in each of the ACGME

e authority to approve or remove faculty members at all participating core faculty members, and must evaluate candidates prior to approval.

e authority to remove residents from rning environments that do not meet e)

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

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

the program's compliance with the id procedures related to grievances ction is taken to suspend or dismiss, or tment of a resident. (Core)

the program's compliance with the Id procedures on employment and non-

sign a non-competition guarantee or

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

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

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

Roman Numeral		Reformatted	
Requirement Number	r Requirement Language	Requirement Number	Requiremer
	Faculty Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and 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 Faculty members are a foundational education – faculty members teach r Faculty members provide an importa and become practice-ready, ensuring quality of care. They are role models by demonstrating compassion, com- patient care, professionalism, and a Faculty members experience the prior development of future colleagues. The the opportunity to teach and model of scholarly approach to patient care, for graduate medical education system, and the population.
II.B.	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 members ensure that patient from a specialist in the field. They re the patients, residents, community, a provide appropriate levels of superv Faculty members create an effective professional manner and attending t 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 or instruct and supervise all residents.
II.B.1.a)	To provide a well-rounded educational experience, some faculty members should have subspecialty education and/or concentrate their practice in one or more subspecialized urological domains (e.g., voiding dysfunction; female urology; reconstruction oncology; calculus disease; pediatrics; sexual dysfunction; and infertility). (Core)	2.7.a.	To provide a well-rounded educational e should have subspecialty education and more subspecialized urological domains urology; reconstruction oncology; calcul dysfunction; and infertility). (Core)
II.B.1.b)	The faculty should include individuals with experience with the following urologic techniques: endo-urology; minimally invasive intra-abdominal and pelvic surgical techniques (such as laparoscopy and robotic surgery); major flank and pelvic surgery; urologic imaging; and microsurgery. (Detail)		The faculty should include individuals w techniques: endo-urology; minimally inv surgical techniques (such as laparoscop pelvic surgery; urologic imaging; and m
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 mode
	demonstrate commitment to the delivery of safe, equitable, high-quality,	-	Faculty members must demonstrate
II.B.2.b)	cost-effective, patient-centered care; (Core)	2.8.a.	equitable, high-quality, cost-effective
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 residents, including devoting sufficien fulfill their supervisory and teaching
II.B.2.d)	administer and maintain an educational environment conducive to educating residents; (Core)	2.8.c.	Faculty members must administer ar environment conducive to educating
II.B.2.e)	regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)	2.8.d.	Faculty members must regularly part discussions, rounds, journal clubs, a
II.B.2.f)	pursue faculty development designed to enhance their skills at least annually: (Core)	2.8.e.	Faculty members must pursue facult their skills at least annually: (Core)

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

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

of faculty members with competence to ... (Core)

I experience, some faculty members nd/or concentrate their practice in one or ns (e.g., voiding dysfunction; female culus disease; pediatrics; sexual

with experience with the following urologic nvasive intra-abdominal and pelvic opy and robotic surgery); major flank and microsurgery. (Detail)

lels of professionalism. (Core) e commitment to the delivery of safe, ve, patient-centered care. (Core)

e a strong interest in the education of cient time to the educational program to g responsibilities. (Core)

and maintain an educational ig residents. (Core)

rticipate in organized clinical , and conferences. (Core)

Ity development designed to enhance

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
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 h (Detail)
II.B.2.f).(3)	in fostering their own and their residents' well-being; and, (Detail)	2.8.e.3.	in fostering their own and their reside
II.B.2.f).(4)	in patient care based on their practice-based learning and improvement efforts. (Detail)	2.8.e.4.	in patient care based on their practice efforts. (Detail)
II.B.3.	Faculty Qualifications	2.9.	Faculty Qualifications Faculty members must have appropri hold appropriate institutional appoint
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 appropri hold appropriate institutional appoint
II.B.3.b)	Physician faculty members must:	[None]	
II.B.3.b).(1)	have current certification in the specialty by the American Board of Urology or the American Osteopathic Board of Surgery, or possess qualifications judged acceptable to the Review Committee. (Core)	2.10.	Physician faculty members must have by the American Board of Urology or f Surgery, or possess qualifications juc 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 si supervision of residents and must de entire effort to resident education and component of their activities, teach, e feedback to residents. (Core)
II.B.4.a)	Core faculty members must complete the annual ACGME Faculty Survey. (Core)	2.11.a.	Core faculty members must complete (Core)
II.B.4.b)	In addition to the program director, there must be a minimum of two core clinical urology faculty members who devote sufficient time to supervise and teach the residents, and who are committed fully to the educational objectives of the program. (Core)	2.11.b.	In addition to the program director, there urology faculty members who devote su residents, and who are committed fully t program. (Core)
II.B.4.c)	There must be a core faculty-to-resident ratio of at least 1:2. (Core)	2.11.c.	There must be a core faculty-to-resident
II.C.	Program Coordinator	2.12.	Program Coordinator There must be a program coordinator
II.C.1.	There must be a program coordinator. (Core)	2.12.	Program Coordinator There must be a program coordinator
II.C.2.	The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)	2.12.a.	The program coordinator must be pro support adequate for administration of and configuration. (Core)
	At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. (Core)		At a minimum, the program coordinator time and support specified below for adr
	Number of Approved Resident Positions: 1-5   Minimum FTE: 0.5 Number of Approved Resident Positions: 6-10   Minimum FTE: 0.7 Number of Approved Resident Positions: 11-15   Minimum FTE: 0.8 Number of Approved Resident Positions: 16-20   Minimum FTE: 0.9		Number of Approved Resident Positions Number of Approved Resident Positions Number of Approved Resident Positions Number of Approved Resident Positions
II.C.2.a)	Number of Approved Resident Positions: ≥ 21   Minimum FTE: 1.0	2.12.b.	Number of Approved Resident Positions

il)

health inequities, and patient safety;

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

priate qualifications in their field and intments. (Core)

priate qualifications in their field and intments. (Core)

ave current certification in the specialty r the American Osteopathic Board of udged acceptable to the Review

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

ete the annual ACGME Faculty Survey.

ere must be a minimum of two core clinical sufficient time to supervise and teach the y to the educational objectives of the

ent ratio of at least 1:2. (Core)

tor. (Core)

tor. (Core)

provided with dedicated time and n of the program based upon its size

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

ons: 1-5 | Minimum FTE: 0.5 ons: 6-10 | Minimum FTE: 0.7 ons: 11-15 | Minimum FTE: 0.8 ons: 16-20 | Minimum FTE: 0.9 ons: ≥ 21 | Minimum FTE: 1.0

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
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 ensure the availability of necessary p administration 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 fo for appointment to an ACGME-accred
III.A.1.	An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)	3.2.	Eligibility Requirements An applicant must meet one of the fo for appointment to an ACGME-accred
III.A.1.a)	graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)	3.2.a.	graduation from a medical school in t Liaison Committee on Medical Educa college of osteopathic medicine in th American Osteopathic Association C Accreditation (AOACOCA); or, (Core)
III.A.1.b)	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)	3.2.b.	<ul> <li>graduation from a medical school our meeting one of the following addition</li> <li>holding a currently valid certificate to Foreign Medical Graduates (ECFMG)</li> <li>holding a full and unrestricted licent States licensing jurisdiction in which located. (Core)</li> </ul>
III.A.1.b).(1)	holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)	3.2.b.	graduation from a medical school our meeting one of the following addition • holding a currently valid certificate f Foreign Medical Graduates (ECFMG) • holding a full and unrestricted licent States licensing jurisdiction in which located. (Core)
III.A.1.b).(2)	holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)	3.2.b.	graduation from a medical school our meeting one of the following addition • holding a currently valid certificate f Foreign Medical Graduates (ECFMG) • holding a full and unrestricted licen States licensing jurisdiction in which located. (Core)

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

following qualifications to be eligible edited program: (Core)

following qualifications to be eligible edited program: (Core)

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

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

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

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

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

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

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

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

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

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

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Requirement Number	Requirement Language	Requirement Number	Requiremen
III.A.2.	All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)- accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)		or transfer into ACGME-accredited re completed in ACGME-accredited resi residency programs, Royal College of (RCPSC)-accredited or College of Fai accredited residency programs locat programs with ACGME International Accreditation. (Core)
III.A.2.a)	Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)	3.3.a.	Residency programs must receive ve competency in the required clinical fi ACGME-I Milestones evaluations from matriculation. (Core)
III.A.2.b)	Based on educational objectives, an alternative format for admission to a urology residency may include a prerequisite of one year of education prior to the 60-month urology program, which must take place in a surgery program that satisfies the requirements under III.A. (Core)	3.3.a.1.	Based on educational objectives, an alte urology residency may include a prerequite the 60-month urology program, which misatisfies the requirements under 3.3. (Contemport
III.A.2.b).(1)	Programs using the alternative format must still comply with all of the curricular requirements for the 60-month urology program, including those for Uro-1 as outlined in IV.C.3IV.C.3.d). (Core)	3.3.a.1.a.	Programs using the alternative format m requirements for the 60-month urology p outlined in 4.11.a.1-3. (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 appoi 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 and a summative competency-based acceptance of a transferring resident matriculation. (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 a and innovation in graduate medical e organizational affiliation, size, or loca The educational program must suppo knowledgeable, skillful physicians wi It is recognized programs may place leadership, public health, etc. It is exp reflect the nuanced program-specific example, it is expected that a program scientists will have a different curricu community health.
IV.A.	Educational Components The curriculum must contain the following educational components:	4.2.	Educational Components The curriculum must contain the follo

residency programs must be sidency programs, AOA-approved of Physicians and Surgeons of Canada family Physicians of Canada (CFPC)ated in Canada, or in residency al (ACGME-I) Advanced Specialty

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

alternative format for admission to a equisite of one year of education prior to must take place in a surgery program that (Core)

must still comply with all of the curricular y program, including those for Uro-1 as

#### oint more residents than approved by

on of previous educational experiences ed performance evaluation prior to nt, and Milestones evaluations upon

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

port the development of who provide compassionate care.

e different emphasis on research, expected that the program aims will fic goals for it and its graduates; for ram aiming to prepare physicianiculum from one focusing on

#### llowing educational components:

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
	a set of program aims consistent with the Sponsoring Institution's		a set of program aims consistent with
	mission, the needs of the community it serves, and the desired distinctive		mission, the needs of the community
	capabilities of its graduates, which must be made available to program		capabilities of its graduates, which m
IV.A.1.		4.2.a.	applicants, residents, and faculty me
	competency-based goals and objectives for each educational experience		competency-based goals and objecti
	designed to promote progress on a trajectory to autonomous practice.		designed to promote progress on a t
	These must be distributed, reviewed, and available to residents and faculty		These must be distributed, reviewed,
IV.A.2.		4.2.b.	faculty members; (Core)
N/ A 2	delineation of resident responsibilities for patient care, progressive	4.2.0	delineation of resident responsibilitie
IV.A.3.		4.2.c.	responsibility for patient management
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured didactic
	Desidents must be analytical with must stad time to neutisingth in some		Didactic and Clinical Experiences
IV.A.4.a)	Residents must be provided with protected time to participate in core didactic activities. (Core)	4.11.	Residents must be provided with pro didactic activities. (Core)
IV.A.4.a)		4.11.	formal educational activities that pro
IV.A.5.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)	4.2.e.	tools, and techniques. (Core)
		7.2.0.	
			ACGME Competencies
			The Competencies provide a concept
			required domains for a trusted physic These Competencies are core to the
			the specifics are further defined by ea
			trajectories in each of the Competence
IV.B.	ACGME Competencies	[None]	Milestones for each specialty.
	The program must integrate the following ACGME Competencies into the	[]	
IV.B.1.		[None]	The program must integrate all ACGN
			ACGME Competencies – Professiona
	Professionalism		Residents must demonstrate a comm
			adherence to ethical principles. (Core
	Residents must demonstrate a commitment to professionalism and an		
IV.B.1.a)	adherence to ethical principles. (Core)	4.3.	Residents must demonstrate compet
			ACGME Competencies – Professiona
			Residents must demonstrate a comm
			adherence to ethical principles. (Core
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	Residents must demonstrate compet
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)	4.3.a.	compassion, integrity, and respect fo
IV.B.1.a).(1).(b)	responsiveness to patient needs that supersedes self-interest; (Core)	4.3.b.	responsiveness to patient needs that
IV.B.1.a).(1).(c)	cultural humility; (Core)	4.3.c.	cultural humility; (Core)
IV.B.1.a).(1).(d)	respect for patient privacy and autonomy; (Core)	4.3.d.	respect for patient privacy and auton
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)	4.3.e.	accountability to patients, society, an
	respect and responsiveness to diverse patient populations, including but		respect and responsiveness to divers
	not limited to diversity in gender, age, culture, race, religion, disabilities,		not limited to diversity in gender, age
IV.B.1.a).(1).(f)		4.3.f.	national origin, socioeconomic status
	ability to recognize and develop a plan for one's own personal and		ability to recognize and develop a pla
IV.B.1.a).(1).(g)		4.3.g.	professional well-being; and, (Core)
	appropriately disclosing and addressing conflict or duality of interest.		appropriately disclosing and address
IV.B.1.a).(1).(h)		4.3.h.	(Core)

ith the Sponsoring Institution's ty it serves, and the desired distinctive must be made available to program nembers; (Core)

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

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

rotected time to participate in core

romote patient safety-related goals,

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

GME Competencies into the curriculum.

nalism imitment to professionalism and an pre)

etence in:

nalism imitment to professionalism and an pre)

etence in:

for others; (Core)

at supersedes self-interest; (Core)

onomy; (Core)

and the profession; (Core)

erse patient populations, including but ge, culture, race, religion, disabilities, tus, and sexual orientation; (Core)

blan for one's own personal and

ssing conflict or duality of interest.

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremer
IV.B.1.b)	Patient Care and Procedural Skills	[None]	Kequitemer
14.0.1.0			ACGME Competencies – Patient Car
	Residents must be able to provide patient care that is patient- and family-		Residents must be able to provide pa
	centered, compassionate, equitable, appropriate, and effective for the		centered, compassionate, equitable,
IV.B.1.b).(1)	treatment of health problems and the promotion of health. (Core)	4.4.	treatment of health problems and the
	Residents must demonstrate competence in providing direct patient care with		Residents must demonstrate competen
	increasing levels of responsibility in patient management as they advance		increasing levels of responsibility in pat
IV.B.1.b).(1).(a)	through the program. (Core)	4.4.a.	through the program. (Core)
	Residents must, under supervision, demonstrate competence in providing for		Residents must, under supervision, der
	the total care of the patient, including initial evaluation, establishment of		the total care of the patient, including in
	diagnosis, selection of appropriate therapy, providing that therapy, and		diagnosis, selection of appropriate there
IV.B.1.b).(1).(b)	management of complications. (Core)	4.4.b.	management of complications. (Core)
	Residents must demonstrate competence in providing continuity of patient care		Residents must demonstrate competen
IV.B.1.b).(1).(c)	through pre- and post-operative clinics and inpatient contact. (Core)	4.4.c.	through pre- and post-operative clinics
	When residents participate in pre- and post-operative care in a clinic or private		When residents participate in pre- and p
	office setting, the program director must ensure that the resident functions with	4.4.5.4	office setting, the program director mus
IV.B.1.b).(1).(c).(i)	an appropriate degree of responsibility under supervision. (Core)	4.4.c.1.	an appropriate degree of responsibility
	Residents must be given responsibility commensurate with their individual		Residents must be given responsibility
$I \setminus D (1 h) (1) (d)$	knowledge, problem-solving ability, technical skills, experience, and the severity	4.4.d.	knowledge, problem-solving ability, tech
IV.B.1.b).(1).(d)	and complexity of each patient's status. (Core)	4.4.u.	and complexity of each patient's status.
	Residents must be able to perform all medical, diagnostic, and surgical		ACGME Competencies – Patient Care Residents must be able to perform a
IV.B.1.b).(2)	procedures considered essential for the area of practice. (Core)	4.5.	procedures considered essential for
IV.B.1.b).(2).(a)	Residents must develop competence in the following core techniques:	4.5.a.	Residents must develop competence in
IV.B.1.b).(2).(a).(i)	endo-urology; (Core)	4.5.a.1.	endo-urology; (Core)
IV.B.1.b).(2).(a).(ii)	major open flank and pelvic surgery; (Core)	4.5.a.2.	major open flank and pelvic surgery; (C
	minimally invasive intra-abdominal and pelvic surgical techniques including,		minimally invasive intra-abdominal and
IV.B.1.b).(2).(a).(iii)	laparoscopy and robotics; (Core)	4.5.a.3.	laparoscopy and robotics; (Core)
IV.B.1.b).(2).(a).(iv)	perineal and genital surgery; and, (Core)	4.5.a.4.	perineal and genital surgery; and, (Core
IV.B.1.b).(2).(a).(v)	urologic imaging, including fluoroscopy and ultrasound. (Core)	4.5.a.5.	urologic imaging, including fluoroscopy
	Medical Knowledge		
			ACGME Competencies – Medical Kno
	Residents must demonstrate knowledge of established and evolving		Residents must demonstrate knowle
	biomedical, clinical, epidemiological, and social-behavioral sciences,		biomedical, clinical, epidemiological
	including scientific inquiry, as well as the application of this knowledge to		including scientific inquiry, as well a
IV.B.1.c)	patient care. (Core)	4.6.	patient care. (Core)
IV.B.1.c).(1)	Residents must demonstrate knowledge of the following curricular topics:	4.6.a.	Residents must demonstrate knowledge
IV.B.1.c).(1).(a)	bioethics; (Core)	4.6.a.1.	bioethics; (Core)
IV.B.1.c).(1).(b)	biostatistics; (Core)	4.6.a.2.	biostatistics; (Core)
IV.B.1.c).(1).(c)	calculus disease; (Core)	4.6.a.3.	calculus disease; (Core)
IV.B.1.c).(1).(d)	epidemiology; (Core)	4.6.a.4.	epidemiology; (Core)
IV.B.1.c).(1).(e)	evidence-based medicine; (Core)	4.6.a.5.	evidence-based medicine; (Core)
IV.B.1.c).(1).(f)	female pelvic medicine; (Core)	4.6.a.6.	female pelvic medicine; (Core)
IV.B.1.c).(1).(g)	infectious disease; (Core)	4.6.a.7.	infectious disease; (Core)
IV.B.1.c).(1).(h)	infertility and sexual dysfunction; (Core)	4.6.a.8.	infertility and sexual dysfunction; (Core)
IV.B.1.c).(1).(i)	geriatrics; (Core	4.6.a.9.	geriatrics; (Core
IV.B.1.c).(1).(j)	medical oncology; (Core)	4.6.a.10.	medical oncology; (Core)

are and Procedural Skills (Part A)

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

ence in providing direct patient care with atient management as they advance

emonstrate competence in providing for initial evaluation, establishment of erapy, providing that therapy, and

ence in providing continuity of patient care s and inpatient contact. (Core)

d post-operative care in a clinic or private ust ensure that the resident functions with y under supervision. (Core)

y commensurate with their individual chnical skills, experience, and the severity is. (Core)

are and Procedural Skills (Part B) all medical, diagnostic, and surgical or the area of practice. (Core)

in the following core techniques:

Core)

d pelvic surgical techniques including,

re)

y and ultrasound. (Core)

nowledge

ledge of established and evolving al, and social-behavioral sciences, as the application of this knowledge to

ge of the following curricular topics:

e)

## Urology Crosswalk

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IV.B.1.c).(1).(k)	palliative care; (Core)	4.6.a.11.	palliative care; (Core)
IV.B.1.c).(1).(I)	patient safety and quality improvement; (Core)	4.6.a.12.	patient safety and quality improvement;
IV.B.1.c).(1).(m)	pediatric urology; (Core)	4.6.a.13.	pediatric urology; (Core)
IV.B.1.c).(1).(n)	plastic surgery; (Core)	4.6.a.14.	plastic surgery; (Core)
IV.B.1.c).(1).(o)	pre-, intra-, and post-operative aspects of:	4.6.a.15.	pre-, intra-, and post-operative aspects
IV.B.1.c).(1).(o).(i)	endoscopic-urology; (Core)	4.6.a.15.a.	endoscopic-urology; (Core)
IV.B.1.c).(1).(o).(ii)	major open flank and pelvic surgery; (Core)	4.6.a.15.b.	major open flank and pelvic surgery; (C
IV.B.1.c).(1).(o).(iii)	microsurgery; (Core)	4.6.a.15.c.	microsurgery; (Core)
	minimally invasive intra-abdominal and pelvic surgical techniques, including		minimally invasive intra-abdominal and
IV.B.1.c).(1).(o).(iv)	laparoscopy and robotic surgery; (Core)	4.6.a.15.d.	laparoscopy and robotic surgery; (Core)
IV.B.1.c).(1).(o).(v)	perineal and genital surgery; and, (Core)	4.6.a.15.e.	perineal and genital surgery; and, (Core
	urologic imaging, including fluoroscopy, interventional radiology, and ultrasound.		urologic imaging, including fluoroscopy,
IV.B.1.c).(1).(o).(vi)	(Core)	4.6.a.15.f.	(Core)
IV.B.1.c).(1).(p)	radiation safety; (Core)	4.6.a.16.	radiation safety; (Core)
IV.B.1.c).(1).(q)	reconstruction; (Core)	4.6.a.17.	reconstruction; (Core)
IV.B.1.c).(1).(r)	renal transplantation; (Core)	4.6.a.18.	renal transplantation; (Core)
IV.B.1.c).(1).(s)	renovascular disease; (Core)	4.6.a.19.	renovascular disease; (Core)
IV.B.1.c).(1).(t)	trauma; (Core)	4.6.a.20.	trauma; (Core)
IV.B.1.c).(1).(u)	urologic oncology; and, (Core)	4.6.a.21.	urologic oncology; and, (Core)
IV.B.1.c).(1).(v)	voiding dysfunction. (Core)	4.6.a.22.	voiding dysfunction. (Core)
IV.B.1.d)	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-Ba Residents must demonstrate the abil care of patients, to appraise and assi continuously improve patient care ba 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 compet deficiencies, and limits in one's know
IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)	4.7.b.	Residents must demonstrate compet improvement goals. (Core)
IV.B.1.d).(1).(c)	identifying and performing appropriate learning activities; (Core)	4.7.c.	Residents must demonstrate compet appropriate learning activities. (Core
IV.B.1.d).(1).(d)	systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)	4.7.d.	Residents must demonstrate competer practice using quality improvement reducing health care disparities, and of practice improvement. (Core)
	incorporating feedback and formative evaluation into daily practice; and,	47.	Residents must demonstrate compet
IV.B.1.d).(1).(e)	(Core)	4.7.e.	formative evaluation into daily practi
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 compet assimilating evidence from scientific health problems. (Core)
	Interpersonal and Communication Skills		
IV.B.1.e)	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 – Interperson Residents must demonstrate interper result in the effective exchange of int patients, their families, and health pr
			In and the second secon

it; (Core)
s of:
Core
Core)
d pelvic surgical techniques, including re)
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y, interventional radiology, and ultrasound.
Based Learning and Improvement bility to investigate and evaluate their similate scientific evidence, and to
based on constant self-evaluation and
based on constant self-evaluation and
based on constant self-evaluation and etence in identifying strengths,
based on constant self-evaluation and
based on constant self-evaluation and etence in identifying strengths, owledge and expertise. (Core)
etence in identifying strengths, owledge and expertise. (Core) etence in setting learning and etence in identifying and performing
based on constant self-evaluation and etence in identifying strengths, owledge and expertise. (Core) etence in setting learning and etence in identifying and performing re)
etence in identifying strengths, owledge and expertise. (Core) etence in setting learning and etence in identifying and performing re) etence in systematically analyzing t methods, including activities aimed at
etence in identifying strengths, owledge and expertise. (Core) etence in setting learning and etence in identifying and performing re) etence in systematically analyzing t methods, including activities aimed at id implementing changes with the goal etence in incorporating feedback and

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
IV.B.1.e).(1)	Residents must demonstrate competence in	[None]	Kequiterier
	communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage	[]	Residents must demonstrate compet with patients and patients' families, a of socioeconomic circumstances, cu
IV.B.1.e).(1).(a)	interpretive services as required to provide appropriate care to each patient; (Core)	4.8.a.	capabilities, learning to engage interprovide appropriate care to each pati
IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; (Core)	4.8.b.	Residents must demonstrate compet with physicians, other health profess (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 compet member or leader of a health care tea
IV.B.1.e).(1).(d)	educating patients, patients' families, students, other residents, and other health professionals; (Core)	4.8.d.	Residents must demonstrate compet families, students, other residents, a
IV.B.1.e).(1).(e)	acting in a consultative role to other physicians and health professionals; (Core)	4.8.e.	Residents must demonstrate compet to other physicians and health profes
IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible health care records, if applicable. (Core)	4.8.f.	Residents must demonstrate compet timely, and legible health care record
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 communicat to partner with them to assess their of 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-Bas Residents must demonstrate an awar larger context and system of health c social determinants of health, as well other resources to provide optimal he
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 compet health care delivery settings and syst specialty. <sup>(Core)</sup>
IV.B.1.f).(1).(b)	coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)	4.9.b.	Residents must demonstrate compet across the health care continuum and specialty. <sup>(Core)</sup>
IV.B.1.f).(1).(c)	advocating for quality patient care and optimal patient care systems; (Core)	4.9.c.	Residents must demonstrate compet care and optimal patient care system
IV.B.1.f).(1).(d)	participating in identifying system errors and implementing potential systems solutions; (Core)	4.9.d.	Residents must demonstrate compet system errors and implementing pote
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 compet of value, equity, cost awareness, deli analysis in patient and/or population
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 compet finances and its impact on individual
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 compet that promote patient safety and discl simulated). <sup>(Detail)</sup>

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

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

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

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

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

Based Practice vareness of and responsiveness to the n care, including the structural and ell as the ability to call effectively on

health care. (Core)

etence in working effectively in various stems relevant to their clinical

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

etence in advocating for quality patient ms. (Core)

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

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

etence in understanding health care al patients' health decisions. (Core)

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremer
	Residents must learn to advocate for patients within the health care		Residents must learn to advocate for
	system to achieve the patient's and patient's family's care goals, including,		system to achieve the patient's and <b>p</b>
IV.B.1.f).(2)	when appropriate, end-of-life goals. (Core)	4.9.h.	including, when appropriate, end-of-
			Curriculum Organization and Reside
			4.10. Curriculum Structure The curriculum must be structured to experiences, the length of the experi- continuity. These educational experi- supervised patient care responsibilit educational events. (Core)
			4.11. Didactic and Clinical Experience Residents must be provided with pro didactic activities. (Core)
IV.C.	Curriculum Organization and Resident Experiences	4.10 4.12.	4.12. Pain Management The program must provide instructio management if applicable for the spe signs of substance use disorder. (Co
			Curriculum Structure
	The curriculum must be structured to optimize resident educational		The curriculum must be structured to
	experiences, the length of the experiences, and the supervisory continuity.		experiences, the length of the experi
	These educational experiences include an appropriate blend of supervised		continuity. These educational experie
IV.C.1.	patient care responsibilities, clinical teaching, and didactic educational events. (Core)	4.10.	supervised patient care responsibilit educational events. (Core)
IV.C.1.a)	Chief resident rotations must be at least two months in length. (Core)	4.10.a.	Chief resident rotations must be at leas
			Pain Management
	The program must provide instruction and experience in pain management		The program must provide instructio
	if applicable for the specialty, including recognition of the signs of		management if applicable for the spe
IV.C.2.	substance use disorder. (Core)	4.12.	signs of substance use disorder. (Co
IV.C.3.	The program director must be responsible for the design, implementation, and oversight of the Uro-1 year. The Uro-1 year must include: (Core)	4.11.a.	The program director must be responsil oversight of the Uro-1 year. The Uro-1 y
	six months of core surgical education in rotations outside of urology designed to		six months of core surgical education in
	foster competence in basic surgical skills, the peri-operative care of surgical		foster competence in basic surgical skil
IV.C.3.a)	patients, and inter-disciplinary patient care coordination, including: (Core)	4.11.a.1.	patients, and inter-disciplinary patient ca
IV.C.3.a).(1)	three months of general surgery rotations; and, (Core)	4.11.a.1.a.	three months of general surgery rotation
IV.C.3.a).(2)	three months of additional non-urological surgery rotations. (Core)	4.11.a.1.b.	three months of additional non-urologica
IV.C.3.b)	three months of urology rotations designed to develop competence in basic urological skills, general care of the urology patient both in the in-patient and ambulatory setting, management of urology patients in the emergency department, and a foundation of urology knowledge; and, (Core)	4.11.a.2.	three months of urology rotations design urological skills, general care of the uro ambulatory setting, management of uro department, and a foundation of urology
,	three months of clinical rotations designed at the discretion of the program director to further develop basic surgical skills and/or care of urological patients.		three months of clinical rotations design director to further develop basic surgica
IV.C.3.c)		4.11.a.3.	(Core)
IV.C.4.	Non-urology rotations during the Uro-1 year must be at least four weeks in length. (Core)	4.11.b.	Non-urology rotations during the Uro-1 plength. (Core)

# ent Language for patients within the health care patient's family's care goals, of-life goals. (Core) lent Experiences to optimize resident educational eriences, and the supervisory riences include an appropriate blend of ilities, clinical teaching, and didactic ices rotected time to participate in core ion and experience in pain pecialty, including recognition of the Core) to optimize resident educational eriences, and the supervisory riences include an appropriate blend of ilities, clinical teaching, and didactic ast two months in length. (Core) ion and experience in pain pecialty, including recognition of the Core) sible for the design, implementation, and year must include: (Core) in rotations outside of urology designed to kills, the peri-operative care of surgical care coordination, including: (Core) ions; and, (Core) ical surgery rotations. (Core) igned to develop competence in basic rology patient both in the in-patient and rology patients in the emergency ogy knowledge; and, (Core) gned at the discretion of the program ical skills and/or care of urological patients.

1 year must be at least four weeks in

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IV.C.5.	The Uro-2-5 years must include progressive education in clinical urology. (Core)	4.11.c.	The Uro-2-5 years must include progres	
IV.C.5.a)	During the Uro-2-4 years, up to six months may be devoted to non-urological clinical education and/or research consistent with the program aims, and at the discretion of the program director. (Core)	4.11.c.1.	During the Uro-2-4 years, up to six mon clinical education and/or research cons discretion of the program director. (Core	
IV.C.5.b)	Within the final 24 months of urology education, residents must serve at least 12 months as a chief resident. (Core)	4.11.c.2.	Within the final 24 months of urology ec months as a chief resident. (Core)	
IV.C.6.	Didactic Curriculum	4.11.d.	Didactic Curriculum The curriculum must include didactic ins	
IV.C.6.a)	The curriculum must include didactic instruction in the core domains of:	4.11.d.	Didactic Curriculum The curriculum must include didactic ins	
IV.C.6.a).(1)	calculus disease; (Core)	4.11.d.1.	calculus disease; (Core)	
IV.C.6.a).(2)	female pelvic medicine; (Core)	4.11.d.2.	female pelvic medicine; (Core)	
IV.C.6.a).(3)	geriatric urology; (Core)	4.11.d.3.	geriatric urology; (Core)	
IV.C.6.a).(4)	infertility and sexual dysfunction; (Core)	4.11.d.4.	infertility and sexual dysfunction; (Core)	
IV.C.6.a).(5)	pediatric urology; (Core)	4.11.d.5.	pediatric urology; (Core)	
IV.C.6.a).(6)	reconstruction; (Core)	4.11.d.6.	reconstruction; (Core)	
IV.C.6.a).(7)	urologic oncology; (Core)	4.11.d.7.	urologic oncology; (Core)	
IV.C.6.a).(8)	urologic trauma; and, (Core)	4.11.d.8.	urologic trauma; and, (Core)	
IV.C.6.a).(9)	voiding dysfunction. (Core)	4.11.d.9.	voiding dysfunction. (Core)	
IV.C.6.b)	Didactic conferences must include:	4.11.e.	Didactic conferences must include:	
IV.C.6.b).(1)	morbidity and mortality; (Core)	4.11.e.1.	morbidity and mortality; (Core)	
IV.C.6.b).(2)	urological imaging review; and, (Core)	4.11.e.2.	urological imaging review; and, (Core)	
IV.C.6.b).(3)	journal review. (Core)	4.11.e.3.	journal review. (Core)	
IV.C.6.c)	Didactic conferences must be attended by residents and core faculty members, and the list of conferences must include the date, conference topic, the name of the presenter(s), and the names of the faculty members and residents present for each conference. (Core)	4.11.f.	Didactic conferences must be attended and the list of conferences must include the presenter(s), and the names of the for each conference. (Core)	
IV.C.6.d)	The curriculum must include instruction on harassment and implicit bias, which may be delivered through in-person, virtual, synchronous, or asynchronous formats. (Core)	4.11.f.1.	The curriculum must include instruction may be delivered through in-person, vir formats. (Core)	
IV.C.7.	Each graduating resident must perform the minimum number of essential operative cases and case categories as established by the Review Committee. (Core)	4.11.g.	Each graduating resident must perform operative cases and case categories as (Core)	

ressive education in clinical urology. (Core) onths may be devoted to non-urological nsistent with the program aims, and at the ore)

education, residents must serve at least 12

instruction in the core domains of:

instruction in the core domains of:

e)

ed by residents and core faculty members, ude the date, conference topic, the name of ne faculty members and residents present

on on harassment and implicit bias, which virtual, synchronous, or asynchronous

rm the minimum number of essential as established by the Review Committee.

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	Scholarship		
			Scholarship
	Medicine is both an art and a science. The physician is a humanistic		Medicine is both an art and a science
	scientist who cares for patients. This requires the ability to think critically,		scientist who cares for patients. This
	evaluate the literature, appropriately assimilate new knowledge, and		evaluate the literature, appropriately
	practice lifelong learning. The program and faculty must create an		practice lifelong learning. The progra
	environment that fosters the acquisition of such skills through resident		environment that fosters the acquisit
	participation in scholarly activities. Scholarly activities may include		participation in scholarly activities. S
	discovery, integration, application, and teaching.		discovery, integration, application, a
	The ACGME recognizes the diversity of residencies and anticipates that		The ACGME recognizes the diversity
	programs prepare physicians for a variety of roles, including clinicians,		programs prepare physicians for a v
	scientists, and educators. It is expected that the program's scholarship		scientists, and educators. It is expec
	will reflect its mission(s) and aims, and the needs of the community it		will reflect its mission(s) and aims, a
	serves. For example, some programs may concentrate their scholarly		serves. For example, some programs
	activity on quality improvement, population health, and/or teaching, while		activity on quality improvement, pop
	other programs might choose to utilize more classic forms of biomedical		other programs might choose to utili
IV.D.	research as the focus for scholarship.	[None]	research as the focus for scholarship
			Program Responsibilities
			The program must demonstrate evid
IV.D.1.	Program Responsibilities	4.13.	with its mission(s) and aims. (Core)
			Program Responsibilities
	The program must demonstrate evidence of scholarly activities consistent		The program must demonstrate evid
IV.D.1.a)	with its mission(s) and aims. (Core)	4.13.	with its mission(s) and aims. (Core)
	The program, in partnership with its Sponsoring Institution, must allocate		The program, in partnership with its
	adequate resources to facilitate resident and faculty involvement in		adequate resources to facilitate resid
IV.D.1.b)	scholarly activities. (Core)	4.13.a.	scholarly activities. (Core)
	The program must advance residents' knowledge and practice of the		The program must advance residents
IV.D.1.c)	scholarly approach to evidence-based patient care. (Core)	4.13.b.	scholarly approach to evidence-base
			Faculty Scholarly Activity
			Among their scholarly activity, progr
			accomplishments in at least three of
			<ul> <li>Research in basic science, education</li> </ul>
			or population health
			Peer-reviewed grants
			<ul> <li>Quality improvement and/or patient</li> </ul>
			<ul> <li>Systematic reviews, meta-analyses</li> </ul>
			textbooks, or case reports
			<ul> <li>Creation of curricula, evaluation too</li> </ul>
			electronic educational materials
			<ul> <li>Contribution to professional commit</li> </ul>
			editorial boards
IV.D.2.	Faculty Scholarly Activity	4.14.	<ul> <li>Innovations in education</li> </ul>

ice. The physician is a humanistic his requires the ability to think critically, ly assimilate new knowledge, and gram and faculty must create an sition of such skills through resident . Scholarly activities may include , and teaching.

ity of residencies and anticipates that variety of roles, including clinicians, ected that the program's scholarship , and the needs of the community it ms may concentrate their scholarly opulation health, and/or teaching, while tilize more classic forms of biomedical hip.

idence of scholarly activities consistent

idence of scholarly activities consistent

ts Sponsoring Institution, must allocate sident and faculty involvement in

nts' knowledge and practice of the sed patient care. (Core)

grams must demonstrate of the following domains: (Core)

tion, translational science, patient care,

ent safety initiatives es, review articles, chapters in medical

tools, didactic educational activities, or

mittees, educational organizations, or

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

grams must demonstrate of the following domains: (Core)

tion, translational science, patient care,

nt safety initiatives s, review articles, chapters in medical

ools, didactic educational activities, or

nittees, educational organizations, or

semination of scholarly activity within following methods:

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

ome)

semination of scholarly activity within following methods:

nds, posters, workshops, quality m presentations, grant leadership, nonurces, articles or publications, book vice on professional committees, or nal editorial board member, or editor;

ome)

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Requirement Number		Requirement Number	
			The program must demonstrate diss and external to the program by the fo
			<ul> <li>faculty participation in grand round improvement presentations, podium peer-reviewed print/electronic resour chapters, textbooks, webinars, servio serving as a journal reviewer, journa (Outcome)</li> </ul>
IV.D.2.b).(2)	peer-reviewed publication. (Outcome)	4.14.a.	peer-reviewed publication. (Outcor
10.0.2.0).(2)		4. 14.d.	Resident Scholarly Activity
IV.D.3.	Resident Scholarly Activity	4.15.	Residents must participate in schola
IV.D.3.a)	Residents must participate in scholarship. (Core)	4.15.	Resident Scholarly Activity Residents must participate in schola
IV.D.3.b)	The program must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)	4.15.a.	The program must advance residents' k research, including how research is con and applied to patient care. (Core)
V.	Evaluation	Section 5	Section 5: Evaluation
V.A.	Resident Evaluation	5.1.	Resident Evaluation: Feedback and E Faculty members must directly obser feedback on resident performance du educational assignment. (Core)
V.A.1.	Feedback and Evaluation	5.1.	Resident Evaluation: Feedback and E Faculty members must directly obse feedback on resident performance du 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 E Faculty members must directly obser feedback on resident performance du educational assignment. (Core)
V.A.1.b)	Evaluation must be documented at the completion of the assignment. (Core)	5.1.a.	Evaluation must be documented at th (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 th must be documented at least every t
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 co clinical responsibilities, must be eva and at completion. (Core)
V.A.1.c)	The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)	5.1.b.	The program must provide an object the Competencies and the specialty-
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 evalupatients, self, and other professional
V.A.1.c).(1).(a)	There must be a minimum of three different sources of evaluations. (Detail)	5.1.b.1.a.	There must be a minimum of three diffe
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 inform Committee for its synthesis of progra improvement toward unsupervised p

ent Language
semination of scholarly activity within following methods:
nds, posters, workshops, quality n presentations, grant leadership, non- urces, articles or publications, book vice on professional committees, or al editorial board member, or editor;
ome)
arship. (Core)
arship. (Core)
knowledge of the basic principles of bonducted, evaluated, explained to patients,
Evaluation erve, evaluate, and frequently provide during each rotation or similar
l Evaluation erve, evaluate, and frequently provide during each rotation or similar
Evaluation erve, evaluate, and frequently provide during each rotation or similar
the completion of the assignment.
three months in duration, evaluation three months. (Core)
continuity clinic in the context of other aluated at least every three months
ctive performance evaluation based on /-specific Milestones. <sup>(Core)</sup>
luators (e.g., faculty members, peers, al staff members). (Core)
ferent sources of evaluations. (Detail)
ormation to the Clinical Competency ressive resident performance and practice. (Core)

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V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:	[None]	· ·
V.A.1.d).(1)	meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)	5.1.c.	The program director or their design Competency Committee, must meet their documented semi-annual evalu progress along the specialty-specific
V.A.1.d).(1).(a)	This must include review of the procedural experiences of each resident, including the number of cases recorded to ensure that the operative procedures performed by residents are entered in the ACGME Case Log System. (Core)	5.1.c.1.	This must include review of the procedu including the number of cases recorded performed by residents are entered in the
V.A.1.d).(1).(b)	This should include review of the procedural experiences of each resident to ensure there is equal opportunity for a variety of operative experiences. (Detail)	5.1.c.2.	This should include review of the proce ensure there is equal opportunity for a v
V.A.1.d).(2)	assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)	5.1.d.	The program director or their design Competency Committee, must assist individualized learning plans to capit areas for growth. (Core)
V.A.1.d).(3)	develop plans for residents failing to progress, following institutional policies and procedures. (Core)	5.1.e.	The program director or their design Competency Committee, must developrogress, following institutional polic
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 su that includes their readiness to progr 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 perfo by the resident. (Core)
V.A.1.g)	Assessment must specifically include monitoring the resident's medical knowledge by use of a formal examination such as an in-service examination or other cognitive examinations. (Core)	5.1.h.	Assessment must specifically include m knowledge by use of a formal examinat other cognitive examinations. (Core)
V.A.1.g).(1)	Test results should be reviewed annually and utilized to guide program curriculum and individual resident study plans. (Detail)	5.1.h.1.	Test results should be reviewed annual curriculum and individual resident study
V.A.1.g).(2)	Test results should not be used as the sole criterion of resident knowledge and should not be used as the sole criterion for promotion to a subsequent PG level. (Detail)	5.1.h.2.	Test results should not be used as the s should not be used as the sole criterion (Detail)
			Resident Evaluation: Final Evaluation
V.A.2.	Final Evaluation	5.2.	The program director must provide a upon completion of the program. (Co
V.A.2.a)	The program director must provide a final evaluation for each resident upon completion of the program. (Core)	5.2.	Resident Evaluation: Final Evaluation The program director must provide a upon completion of the program. (Co
V.A.2.a).(1)		5.2.a.	The specialty-specific Milestones, an specific Case Logs, must be used as engage in autonomous practice upor
V.A.2.a).(2)	The final evaluation must:	[None]	

gnee, with input from the Clinical et with and review with each resident luation of performance, including fic Milestones. (Core)

dural experiences of each resident, ed to ensure that the operative procedures a the ACGME Case Log System. (Core)

cedural experiences of each resident to a variety of operative experiences. (Detail)

gnee, with input from the Clinical ist residents in developing pitalize on their strengths and identify

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

summative evaluation of each resident ogress to the next year of the program, if

formance must be accessible for review

monitoring the resident's medical nation such as an in-service examination or

ually and utilized to guide program idy plans. (Detail)

e sole criterion of resident knowledge and on for promotion to a subsequent PG level.

#### ion

e a final evaluation for each resident Core)

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a final evaluation for each resident Core)

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

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	become part of the resident's permanent record maintained by the		The final evaluation must become pa
	institution, and must be accessible for review by the resident in		maintained by the institution, and mu
V.A.2.a).(2).(a)	accordance with institutional policy; (Core)	5.2.b.	resident in accordance with institution
			The final evaluation must verify that t
	verify that the resident has demonstrated the knowledge, skills, and		knowledge, skills, and behaviors nec
V.A.2.a).(2).(b)	behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	(Core)
			The final evaluation must be shared w
V.A.2.a).(2).(c)	be shared with the resident upon completion of the program. (Core)	5.2.d.	the program. (Core)
			Clinical Competency Committee
	A Clinical Competency Committee must be appointed by the program		A Clinical Competency Committee m
V.A.3.	director. (Core)	5.3.	director. (Core)
	At a minimum, the Clinical Competency Committee must include three		At a minimum, the Clinical Competen
	members of the program faculty, at least one of whom is a core faculty		members of the program faculty, at le
V.A.3.a)	member. (Core)	5.3.a.	member. (Core)
	Additional members must be faculty members from the same program or		Additional members must be faculty
	other programs, or other health professionals who have extensive contact		other programs, or other health profe
V.A.3.a).(1)	and experience with the program's residents. (Core)	5.3.b.	and experience with the program's re
V.A.3.b)	The Clinical Competency Committee must:	[None]	
			The Clinical Competency Committee
V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)	5.3.c.	at least semi-annually. (Core)
	determine each resident's progress on achievement of the specialty-		The Clinical Competency Committee
V.A.3.b).(2)	specific Milestones; and, (Core)	5.3.d.	progress on achievement of the spec
			The Clinical Competency Committee
	meet prior to the residents' semi-annual evaluations and advise the		semi-annual evaluations and advise t
V.A.3.b).(3)	program director regarding each resident's progress. (Core)	5.3.e.	resident's progress. (Core)
			Faculty Evaluation
			The program must have a process to
V.B.	Faculty Evaluation	5.4.	performance as it relates to the educa
ν.в.	Faculty Evaluation	5.4.	(Core)
			Faculty Evaluation
	The program must have a process to evaluate each faculty member's		The program must have a process to
V.B.1.	performance as it relates to the educational program at least annually.	5.4.	performance as it relates to the educa
V.D.1.		5.4.	(Core)
	This evaluation must include a review of the faculty member's clinical		This evaluation must include a review
	teaching abilities, engagement with the educational program, participation		teaching abilities, engagement with the
V.B.1.a)	in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)	5.4.a.	in faculty development related to thei performance, professionalism, and se
<b>v</b> .D.1.a)		J.4.a.	This evaluation must include written,
V.B.1.b)	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)	5.4.b.	evaluations by the residents. (Core)
	Faculty members must receive feedback on their evaluations at least		Faculty members must receive feedb
V.B.2.	annually. (Core)	5.4.c.	annually. (Core)
•	Results of the faculty educational evaluations should be incorporated into	v. <del>v</del> .v.	Results of the faculty educational eva
V.B.3.	program-wide faculty development plans. (Core)	5.4.d.	program-wide faculty development p
v.ப.v.		v. <del>.</del> .	
			Program Evaluation and Improvemen
			The program director must appoint the conduct and document the Annual Pr
V.C.	Program Evaluation and Improvement	5.5.	program's continuous improvement
<b>v</b> .o.		5.5.	program s continuous improvement p

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

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

with the resident upon completion of

#### must be appointed by the program

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

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

e must review all resident evaluations

e must determine each resident's ecialty-specific Milestones. (Core)

e must meet prior to the residents' e the program director regarding each

to evaluate each faculty member's icational program at least annually.

to evaluate each faculty member's ıcational program at least annually.

ew of the faculty member's clinical I the educational program, participation Ieir skills as an educator, clinical scholarly activities. (Core)

n, anonymous, and confidential

back on their evaluations at least

valuations should be incorporated into plans. (Core)

ent

the Program Evaluation Committee to Program Evaluation as part of the t process. (Core)

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Requirement Number	Requirement Language	Requirement Number	Requirement Language
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 E conduct and document the Annual Program Evalu program's continuous improvement process. (Con
	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member,		The Program Evaluation Committee must be comp program faculty members, at least one of whom is
V.C.1.a)	and at least one resident. (Core)	5.5.a.	and at least one resident. (Core)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
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 m program's self-determined goals and progress to
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 m ongoing program improvement, including develop based upon outcomes. (Core)
V.C.1.b).(3)	review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee responsibilities m current operating environment to identify strength opportunities, and threats as related to the progra (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 prior Annual Program Evaluation(s), aggregate resevaluations of the program, and other relevant date 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 and aims, strengths, areas for improvement, and t
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 act distributed to and discussed with the residents an teaching faculty, and be submitted to the DIO. (Co
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 sub
	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		Board Certification One goal of ACGME-accredited education is to ed seek and achieve board certification. One measur the educational program is the ultimate pass rate. The program director should encourage all eligible take the certifying examination offered by the app
V.C.3.	of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.	[None]	of Medical Specialties (ABMS) member board or A 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 board offer(s) an annual written exam, in the prece program's aggregate pass rate of those taking the time must be higher than the bottom fifth percenti 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)		For specialties in which the ABMS member board board offer(s) a biennial written exam, in the prece program's aggregate pass rate of those taking the time must be higher than the bottom fifth percenti specialty. <sup>(Outcome)</sup>

**Evaluation Committee to** luation as part of the ore)

nposed of at least two is a core faculty member,

must include review of the oward meeting them. (Core) must include guiding opment of new goals,

must include review of the ths, challenges, ram's mission and aims.

sider the outcomes from resident and faculty written lata in its assessment of

ate the program's mission I threats. (Core)

ction plan, must be and the members of the Core) Ibmit it to the DIO. (Core)

educate physicians who ure of the effectiveness of e.

ble program graduates to plicable American Board American Osteopathic

d and/or AOA certifying ceding three years, the he examination for the first ntile of programs in that

d and/or AOA certifying ceding six years, the he examination for the first ntile of programs in that

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremer
	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		For specialties in which the ABMS me board offer(s) an annual oral exam, in program's aggregate pass rate of the time must be higher than the bottom
V.C.3.c)	specialty. (Outcome)	5.6.b.	specialty. <sup>(Outcome)</sup>
V.C.3.d)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.c.	For specialties in which the ABMS me board offer(s) a biennial oral exam, in program's aggregate pass rate of the time must be higher than the bottom specialty. <sup>(Outcome)</sup>
	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		For each of the exams referenced in a graduates over the time period specian 80 percent pass rate will have met
V.C.3.e)	percentile rank of the program for pass rate in that specialty. (Outcome)	5.6.d.	percentile rank of the program for pa
V.C.3.f)	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)	5.6.e.	Programs must report, in ADS, board cohort of board-eligible residents that
			Section 6: The Learning and Working
	The Learning and Working Environment		The Learning and Working Environm
	Residency education must occur in the context of a learning and working environment that emphasizes the following principles:		Residency education must occur in t environment that emphasizes the fol
	<ul> <li>Excellence in the safety and quality of care rendered to patients by residents today</li> </ul>		<ul> <li>Excellence in the safety and quality residents today</li> </ul>
	<ul> <li>Excellence in the safety and quality of care rendered to patients by today's residents in their future practice</li> </ul>		• Excellence in the safety and quality today's residents in their future pract
	• Excellence in professionalism		• Excellence in professionalism
	<ul> <li>Appreciation for the privilege of caring for patients</li> </ul>		• Appreciation for the privilege of car
VI.	<ul> <li>Commitment to the well-being of the students, residents, faculty members, and all members of the health care team</li> </ul>	Section 6	• Commitment to the well-being of the members, and all members of the heat
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]	
	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		Culture of Safety A culture of safety requires continuo and a willingness to transparently de organization has formal mechanisms attitudes of its personnel toward safe
VI.A.1.a).(1)		[None]	improvement.

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

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

in 5.6.a.-c., any program whose ecified in the requirement have achieved net this requirement, no matter the pass rate in that specialty. <sup>(Outcome)</sup>

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

#### ng Environment

ment

the context of a learning and working ollowing principles:

ity of care rendered to patients by

ty of care rendered to patients by actice

aring for patients

the students, residents, faculty realth care team

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

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Requirement Number	Requirement Language	Requirement Number	
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, an patient safety systems and contribute
	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		Patient Safety Events Reporting, investigation, and follow-u unsafe conditions are pivotal mechar and are essential for the success of a and experiential learning are essentia the ability to identify causes and inst
VI.A.1.a).(2)	changes to ameliorate patient safety vulnerabilities.	[None]	changes to ameliorate patient safety
VI.A.1.a).(2).(a)	Residents, fellows, faculty members, and other clinical staff members must:	[None]	
	know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)	6.2.	Residents, fellows, faculty members, must know their responsibilities in re unsafe conditions at the clinical site, (Core)
	be provided with summary information of their institution's patient safety reports. (Core)	6.2.a.	Residents, fellows, faculty members, must be provided with summary info safety reports. <sup>(Core)</sup>
VI.A.1.a).(2).(b)	Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)	6.3.	Residents must participate as team n interprofessional clinical patient safe such as root cause analyses or other well as formulation and implementati
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 prioritiz and evaluating success of improvem
	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 benchmarks related to their patient p
			Supervision and Accountability Although the attending physician is u the patient, every physician shares in accountability for their efforts in the p programs, in partnership with their S communicate, and monitor a structur accountability as it relates to the sup
VI.A.2.	Supervision and Accountability	[None]	Supervision in the setting of graduate and effective care to patients; ensure skills, knowledge, and attitudes requi practice of medicine; and establishes professional growth.

ent Language and fellows must actively participate in ite to a culture of safety. (Core)

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

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

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

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

itizing activities for care improvement ment efforts.

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

s ultimately responsible for the care of in the responsibility and e provision of care. Effective Sponsoring Institutions, define, widely fured chain of responsibility and upervision of all patient care.

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
	Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care. Supervision 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		Supervision and Accountability Although the attending physician is u the patient, every physician shares in accountability for their efforts in the p programs, in partnership with their Sp communicate, and monitor a structur accountability as it relates to the super Supervision in the setting of graduate and effective care to patients; ensure skills, knowledge, and attitudes requi practice of medicine; and establishes
VI.A.2.a)	professional growth.	[None]	professional growth. Residents and faculty members must
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.	respective roles in that patient's care This information must be available to members of the health care team, and
VI.A.2.a).(1).(a)	This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)	6.5.	Residents and faculty members must respective roles in that patient's care This information must be available to members of the health care team, and
VI.A.2.a).(1).(a).(i)	The Review Committee recognizes only physician faculty members as appropriate faculty supervisors for residents. (Core)	6.5.a.	The Review Committee recognizes only appropriate faculty supervisors for reside
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 t place for all residents is based on eac ability, as well as patient complexity a exercised through a variety of method (Core)
VI.A.2.b)	Levels of Supervision To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:	[None]	Levels of Supervision To promote appropriate resident supe authority and responsibility, the prog classification of supervision.
VI.A.2.b).(1)	Direct Supervision:	6.7.	Direct Supervision The supervising physician is physical the key portions of the patient interac The supervising physician and/or pat the resident and the supervising physician patient care through appropriate teled
VI.A.2.b).(1).(a)	the supervising physician is physically present with the resident during	6.7.	Direct Supervision The supervising physician is physical the key portions of the patient interac The supervising physician and/or pat the resident and the supervising physician patient care through appropriate teleo

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

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

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

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

ly physician faculty members as idents. (Core)

t the appropriate level of supervision in each resident's level of training and y and acuity. Supervision may be ods, as appropriate to the situation.

pervision while providing for graded ogram must use the following

cally present with the resident during action.

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

cally present with the resident during action.

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
VI.A.2.b).(1).(a).(i)	PGY-1 residents must initially be supervised directly, only as described in VI.A.2.b).(1).(a). (Core)	6.7.a.	PGY-1 residents must initially be sup the above definition. (Core)
			Direct Supervision The supervising physician is physica the key portions of the patient interac
VI.A.2.b).(1).(b)	the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.	6.7.	The supervising physician and/or pat the resident and the supervising physical patient care through appropriate television
VI.A.2.b).(1).(b).(i)	The use of telecommunication technology for direct supervision must be limited to non-procedural patient evaluations and examinations, in either the ambulatory or acute care setting. (Core)	6.7.b.	The use of telecommunication technolog to non-procedural patient evaluations an ambulatory or acute care setting. (Core)
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 prov or audio supervision but is immediate guidance and is available to provide a
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 availabl procedures/encounters with feedback
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physi physician is required. (Core)
VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)	6.9.	The privilege of progressive authority independence, and a supervisory role resident must be assigned by the pro (Core)
VI.A.2.d).(1)	The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)	6.9.a.	The program director must evaluate e specific criteria, guided by the Milester
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 super portions of care to residents based of 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 se residents in recognition of their progr the needs of each patient and the skil (Detail)
VI.A.2.e)	Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)	6.10.	Programs must set guidelines for circ residents must communicate with the (Core)
VI.A.2.e).(1)	Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)	6.10.a.	Each resident must know the limits or circumstances under which the resid 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 the knowledge and skills of each resi the appropriate level of patient care a

pervised directly, only as described in

cally present with the resident during action.

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

ogy for direct supervision must be limited and examinations, in either the e)

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

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

ity and responsibility, conditional ble in patient care delegated to each rogram director and faculty members.

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

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

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

ircumstances and events in which he supervising faculty member(s).

of their scope of authority, and the ident is permitted to act with ne)

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

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Requirement Number	Requirement Language	Requirement Number	Requiremen
VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with their S residents and faculty members conce responsibilities of physicians, includ to be appropriately rested and fit to p 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 S residents and faculty members conce responsibilities of physicians, includ to be appropriately rested and fit to p 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 progra excessive reliance on residents to ful
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the progra 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 progra the meaning that each resident finds physician, including protecting time administrative support, promoting pr flexibility, and enhancing professiona
VI.B.3.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)	6.12.d.	The program director, in partnership provide a culture of professionalism personal responsibility. (Core)
VI.B.4.	Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)	6.12.e.	Residents and faculty members must their personal role in the safety and v care, including the ability to report ur (Core)
VI.B.5.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)	6.12.f.	Programs, in partnership with their S a professional, equitable, respectful, psychologically safe and that is free f forms of harassment, mistreatment, a residents, faculty, and staff. (Core)
VI.B.6.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)	6.12.g.	Programs, in partnership with their S process for education of residents ar behavior and a confidential process f addressing such concerns. (Core)

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

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

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

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

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

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

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

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

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Requirement Number	Requirement Language	Requirement Number	Requiremer
	Well-Being		Well Being
	Psychological, emotional, and physical well-being are critical in the		Well-Being Psychological, emotional, and physic
	development of the competent, caring, and resilient physician and require		development of the competent, carin
	proactive attention to life inside and outside of medicine. Well-being		proactive attention to life inside and
	requires that physicians retain the joy in medicine while managing their		requires that physicians retain the jo
	own real-life stresses. Self-care and responsibility to support other		own real-life stresses. Self-care and
	members of the health care team are important components of		members of the health care team are
	professionalism; they are also skills that must be modeled, learned, and		professionalism; they are also skills
	nurtured in the context of other aspects of residency training.		nurtured in the context of other aspe
	Residents and faculty members are at risk for burnout and depression.		Residents and faculty members are a
	Programs, in partnership with their Sponsoring Institutions, have the		Programs, in partnership with their S
	same responsibility to address well-being as other aspects of resident		same responsibility to address well-l
	competence. Physicians and all members of the health care team share		competence. Physicians and all mem
	responsibility for the well-being of each other. A positive culture in a		responsibility for the well-being of ea
	clinical learning environment models constructive behaviors, and		clinical learning environment models
VI.C.	prepares residents with the skills and attitudes needed to thrive throughout their careers.	[None]	prepares residents with the skills and throughout their careers.
VI.C.		[None]	•
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program, in Institution, must include:
1.0.1.	attention to scheduling, work intensity, and work compression that	0.10.	attention to scheduling, work intensi
VI.C.1.a)	impacts resident well-being; (Core)	6.13.a.	impacts resident well-being; (Core)
	evaluating workplace safety data and addressing the safety of residents		evaluating workplace safety data and
VI.C.1.b)		6.13.b.	and faculty members; (Core)
	policies and programs that encourage optimal resident and faculty		policies and programs that encourag
VI.C.1.c)		6.13.c.	member well-being; and, (Core)
	Residents must be given the opportunity to attend medical, mental health,		Residents must be given the opportu
	and dental care appointments, including those scheduled during their		and dental care appointments, includ
VI.C.1.c).(1)	working hours. (Core)	6.13.c.1.	working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty m
	identification of the symptoms of burnout, depression, and substance use		identification of the symptoms of bui
	disorders, suicidal ideation, or potential for violence, including means to		disorders, suicidal ideation, or poten
VI.C.1.d).(1)	assist those who experience these conditions; (Core)	6.13.d.1.	assist those who experience these c
	recognition of these symptoms in themselves and how to seek appropriate		recognition of these symptoms in the
VI.C.1.d).(2)	care; and, (Core)	6.13.d.2.	appropriate care; and, (Core)
VI.C.1.d).(3)	access to appropriate tools for self-screening. (Core)	6.13.d.3.	access to appropriate tools for self-s
	providing access to confidential, affordable mental health assessment,		providing access to confidential, affo
	counseling, and treatment, including access to urgent and emergent care		counseling, and treatment, including
VI.C.1.e)	24 hours a day, seven days a week. (Core)	6.13.e.	24 hours a day, seven days a week. (
	There are circumstances in which residents may be unable to attend work,		There are circumstances in which rea
	including but not limited to fatigue, illness, family emergencies, and		including but not limited to fatigue, il
	medical, parental, or caregiver leave. Each program must allow an		medical, parental, or caregiver leave.
	appropriate length of absence for residents unable to perform their patient		appropriate length of absence for res
VI.C.2.	care responsibilities. (Core)	6.14.	care responsibilities. (Core)
<b>1</b> // <b>0 0 - )</b>	The program must have policies and procedures in place to ensure		The program must have policies and
VI.C.2.a)	coverage of patient care and ensure continuity of patient care. (Core)	6.14.a.	coverage of patient care and ensure

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

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

in partnership with the Sponsoring

sity, and work compression that

nd addressing the safety of residents

age optimal resident and faculty

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

members in:

ournout, depression, and substance use ential for violence, including means to conditions; (Core)

themselves and how to seek

-screening. (Core)

ffordable mental health assessment, ng access to urgent and emergent care . (Core)

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

nd procedures in place to ensure re continuity of patient care. (Core)

Roman Numeral		Reformatted	
<b>Requirement Number</b>	Requirement Language	Requirement Number	Requiremen
	These policies must be implemented without fear of negative		These policies must be implemented
	consequences for the resident who is or was unable to provide the clinical		consequences for the resident who is
VI.C.2.b)	work. (Core)	6.14.b.	work. (Core)
			Fatigue Mitigation
			Programs must educate all residents of the signs of fatigue and sleep dep
VI.D.	Fatigue Mitigation	6.15.	fatigue mitigation processes. (Detail)
			Fatigue Mitigation
	Programs must educate all residents and faculty members in recognition		Programs must educate all residents
	of the signs of fatigue and sleep deprivation, alertness management, and		of the signs of fatigue and sleep dep
VI.D.1.	fatigue mitigation processes. (Detail)	6.15.	fatigue mitigation processes. (Detail)
	The program, in partnership with its Sponsoring Institution, must ensure		The program, in partnership with its
	adequate sleep facilities and safe transportation options for residents who		adequate sleep facilities and safe trai
VI.D.2.	may be too fatigued to safely return home. (Core)	6.16.	may be too fatigued to safely return h
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
	Clinical Responsibilities		Clinical Responsibilities
	The clinical responsibilities for each resident must be based on PGY level,		The clinical responsibilities for each
VI.E.1.	patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)	6.17.	patient safety, resident ability, severi illness/condition, and available supp
VI.C. I.		0.17.	· · · ·
	The program director must establish written guidelines for the assignment of clinical responsibilities by Uro level, including clinic volume, on-call frequency		The program director must establish wri clinical responsibilities by Uro level, incl
	and back-up requirements, and the appropriate role in surgical procedures.		and back-up requirements, and the app
VI.E.1.a)	(Core	6.17.a.	(Core)
,	Teamwork		
			Teamwork
	Residents must care for patients in an environment that maximizes		Residents must care for patients in a
	communication and promotes safe, interprofessional, team-based care in		communication and promotes safe, in
VI.E.2.		6.18.	the specialty and larger health system
VI.E.2.a)	Each resident must have the opportunity to interact with nurses, social workers, and other health care providers. (Core)	6.18.a.	Each resident must have the opportunity and other health care providers. (Core)
vi.L.2.a)		0.10.a.	Transitions of Care
			Programs must design clinical assign
VI.E.3.	Transitions of Care	6.19.	patient care, including their safety, fr
			Transitions of Care
	Programs must design clinical assignments to optimize transitions in		Programs must design clinical assign
VI.E.3.a)	patient care, including their safety, frequency, and structure. (Core)	6.19.	patient care, including their safety, fr
	Programs, in partnership with their Sponsoring Institutions, must ensure		Programs, in partnership with their S
	and monitor effective, structured hand-off processes to facilitate both		and monitor effective, structured han
VI.E.3.b)	continuity of care and patient safety. (Core)	6.19.a.	continuity of care and patient safety.
	Programs must ensure that residents are competent in communicating	C 40 h	Programs must ensure that residents
VI.E.3.c)	with team members in the hand-off process. (Outcome)	6.19.b.	with team members in the hand-off p
	Clinical Experience and Education		
	Programs in partnership with their Cremering Institutions, much desire		Clinical Experience and Education
	<i>Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with</i>		Programs, in partnership with their S an effective program structure that is
	educational and clinical experience opportunities, as well as reasonable		educational and clinical experience of
VI.F.		[None]	opportunities for rest and personal a

ed without fear of negative is or was unable to provide the clinical

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

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

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

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

vritten guidelines for the assignment of cluding clinic volume, on-call frequency propriate role in surgical procedures.

#### an environment that maximizes interprofessional, team-based care in em. (Core)

nity to interact with nurses, social workers, ∋)

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

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

Sponsoring Institutions, must ensure and-off processes to facilitate both y. (Core)

its are competent in communicating process. (Outcome)

Sponsoring Institutions, must design is configured to provide residents with opportunities, as well as reasonable activities.

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
	Maximum Hours of Clinical and Educational Work per Week		Maximum Hours of Clinical and Educ
	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-		Clinical and educational work hours hours hours per week, averaged over a four
VI.F.1.	house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)	6.20.	house clinical and educational activitian and all moonlighting. (Core)
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	Mandatory Time Free of Clinical Wor Residents should have eight hours o and education periods. (Detail)
	Residents should have eight hours off between scheduled clinical work		Mandatory Time Free of Clinical Worl Residents should have eight hours o
VI.F.2.a)	and education periods. (Detail)	6.21.	and education periods. (Detail)
VI.F.2.b)	Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)	6.21.a.	Residents must have at least 14 hour after 24 hours of in-house call. (Core)
·	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-		Residents must be scheduled for a m clinical work and required education
VI.F.2.c)	home call cannot be assigned on these free days. (Core)	6.21.b.	home call cannot be assigned on the
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	Maximum Clinical Work and Education Clinical and educational work periods hours of continuous scheduled clinic
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 Clinical and educational work periods hours of continuous scheduled clinic
VI.F.3.a).(1)	Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)	6.22.a.	Up to four hours of additional time m patient safety, such as providing effe resident education. Additional patien assigned to a resident during this tim
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	Clinical and Educational Work Hour E In rare circumstances, after handing resident, on their own initiative, may clinical site in the following circumsta a single severely ill or unstable patien needs of a patient or patient's family; events. (Detail)
VI.F.4.a)	In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)	6.23.	Clinical and Educational Work Hour E In rare circumstances, after handing resident, on their own initiative, may clinical site in the following circumsta a single severely ill or unstable patien needs of a patient or patient's family; events. (Detail)
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 edu 80-hour weekly limit. (Detail)
VI.I . <del>.</del>		0.20.a.	ou-nour weekly mint. (Detail)

acational Work per Week s must be limited to no more than 80 ur-week period, inclusive of all invities, clinical work done from home,

ork and Education off between scheduled clinical work

ork and Education off between scheduled clinical work

urs free of clinical work and education e)

minimum of one day in seven free of on (when averaged over four weeks). Atnese free days. (Core)

tion Period Length

ods for residents must not exceed 24 nical assignments. (Core)

ion Period Length

ds for residents must not exceed 24 ical assignments. (Core)

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

**Exceptions** 

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

#### **Exceptions**

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

ducation must be counted toward the

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
	A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.		A Review Committee may grant rotat percent or a maximum of 88 clinical a individual programs based on a sour
VI.F.4.c)	The Review Committee for Urology will not consider requests for exceptions to the 80-hour limit to the residents' work week.	6.24.	The Review Committee for Urology will the 80-hour limit to the residents' work w
VI.F.5.	Moonlighting	6.25.	Moonlighting Moonlighting must not interfere with the goals and objectives of the educa interfere with the resident's fitness for safety. (Core)
VI.F.5.a)	Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)	6.25.	Moonlighting Moonlighting must not interfere with the goals and objectives of the educa interfere with the resident's fitness for 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 an in the ACGME Glossary of Terms) mu 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
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 con seven requirements. (Core)
VI.F.6.a)	Residents cannot be assigned more than eight weeks of night float per year. (Detail)	6.26.a.	Residents cannot be assigned more tha (Detail)
VI.F.7.	Maximum In-House On-Call Frequency Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)	6.27.	Maximum In-House On-Call Frequence Residents must be scheduled for in-h every third night (when averaged ove
VI.F.8.	At-Home Call	6.28.	At-Home Call Time spent on patient care activities count toward the 80-hour maximum v home call is not subject to the every- the requirement for one day in seven when averaged over four weeks. (Cor
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)		At-Home Call Time spent on patient care activities count toward the 80-hour maximum w home call is not subject to the every- the requirement for one day in seven when averaged over four weeks. (Cor
VI.F.8.a).(1)	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)	6.28.a.	At-home call must not be so frequent reasonable personal time for each re

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

Il not consider requests for exceptions to week.

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

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

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

to moonlight. (Core)

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

han eight weeks of night float per year.

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

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

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

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