Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requiremen
	Definition of Graduate Medical Education		Definition of Craduate Madical Educa
	Graduate medical education is the crucial step of professional		Definition of Graduate Medical Educa Graduate medical education is the cru
	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 continuum
	learn to provide optimal patient care under the supervision of faculty		learn to provide optimal patient care u
	members who not only instruct, but serve as role models of excellence,		members who not only instruct, but s
	compassion, cultural sensitivity, professionalism, and scholarship.		compassion, cultural sensitivity, prof
	Graduate medical education transforms medical students into physician		Graduate medical education transform
	scholars who care for the patient, patient's family, and a diverse		scholars who care for the patient, pat
	community; create and integrate new knowledge into practice; and		community; create and integrate new
	educate future generations of physicians to serve the public. Practice		educate future generations of physici
Int.A.	patterns established during graduate medical education persist many years later.	[None]	patterns established during graduate years later.
	Graduate medical education has as a core tenet the graded authority and		Graduate medical education has as a
	responsibility for patient care. The care of patients is undertaken with		responsibility for patient care. The ca
	appropriate faculty supervision and conditional independence, allowing		appropriate faculty supervision and c
	residents to attain the knowledge, skills, attitudes, judgment, and		residents to attain the knowledge, ski
	empathy required for autonomous practice. Graduate medical education		empathy required for autonomous pro
	develops physicians who focus on excellence in delivery of safe,		develops physicians who focus on ex
	equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse		equitable, affordable, quality care; an serve. Graduate medical education va
	group of physicians brings to medical care, and the importance of		group of physicians brings to medica
	inclusive and psychologically safe learning environments.		inclusive and psychologically safe lea
	Graduate medical education occurs in clinical settings that establish the		Graduate medical education occurs in
	foundation for practice-based and lifelong learning. The professional		foundation for practice-based and life
	development of the physician, begun in medical school, continues		development of the physician, begun
	through faculty modeling of the effacement of self-interest in a humanistic		through faculty modeling of the effac
	environment that emphasizes joy in curiosity, problem-solving, academic		environment that emphasizes joy in c
	rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning		rigor, and discovery. This transforma
	environments committed to graduate medical education and the well-		and intellectually demanding and occ environments committed to graduate
	being of patients, residents, fellows, faculty members, students, and all		being of patients, residents, fellows,
Int.A. (Continued)	members of the health care team.	[None] - (Continued)	members of the health care team.
	Definition of Specialty		Definition of Specialty
	Otolaryngologists provide comprehensive medical and surgical care to patients		Otolaryngologists provide comprehensiv
Int D	with diseases and disorders that affect the ears, the respiratory and upper	[None]	with diseases and disorders that affect the
Int.B.	alimentary systems, and related structures of the head and neck.	[None]	alimentary systems, and related structur
l	Length of Educational Program The educational program in otolaryngology – head and neck surgery must be 60		Length of Educational Program The educational program in otolaryngold
	The educational program in otolary hydrogy – nead and neck surgery must be 60		I me euroauonai program in otoiaryngold
Int.C.	months in length. (Core)	4.1.	months in length. (Core)

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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 ical 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 n 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

sive medical and surgical care to patients t the ears, the respiratory and upper ures of the head and neck.

ology – head and neck surgery must be 60

Roman Numeral Requirement		Reformatted Requirement	
Number	Requirement Language	Number	Requirement
	Sponsoring Institution		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.		The Sponsoring Institution is the orga ultimate financial and academic response medical education, consistent with th Requirements.
	When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the		When the Sponsoring Institution is no most commonly utilized site of clinication is not set the set of clinication of the set of the
I.A.	primary clinical site.	[None]	primary clinical site.
I.A.1.	The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)	1.1.	The program must be sponsored by o Institution. (Core)
	Participating Sites		
I.B.	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 Spo primary clinical site. (Core)
	There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the		There must be a program letter of agr and each participating site that gover
I.B.2. I.B.2.a)	program and the participating site providing a required assignment. (Core) The PLA must:	1.3. [None]	program and the participating site pro
I.B.2.a).(1)	be renewed at least every 10 years; and, (Core)	1.3.a.	The PLA must be renewed at least eve
I.B.2.a).(2)	be approved by the designated institutional official (DIO). (Core)	1.3.b.	The PLA must be approved by the des (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 clinica 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 k by the program director as the site dir resident education at that site, in colla (Core)
I.B.4.	The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)	1.6.	The program director must submit an participating sites routinely providing for all residents, of one month full tim the ACGME's Accreditation Data Syst
I.D.4.	The addition of any participating site must be approved by the Review	1.0.	The addition of any participating site must
I.B.5.	Committee prior to assigning any residents to that site. (Core)	1.6.a.	Committee prior to assigning any resider
I.C.	Workforce Recruitment and Retention The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)	1.7.	Workforce Recruitment and Retention The program, in partnership with its S in practices that focus on mission-dri and retention of a diverse and inclusiv present), faculty members, senior adm other relevant members of its academ
I.D.	Resources	1.8.	Resources The program, in partnership with its S the availability of adequate resources

ganization or entity that assumes the ponsibility for a program of graduate the ACGME Institutional

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

one ACGME-accredited Sponsoring

on providing educational experiences ns for residents.

oonsoring Institution, must designate a

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

very 10 years. (Core)

esignated institutional official (DIO).

cal learning and working environment

t be one faculty member, designated lirector, who is accountable for llaboration with the program director.

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

nust be approved by the Review lents to that site. (Core)

on

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

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
I.D.1.	The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)	1.8.	Resources The program, in partnership with its S the availability of adequate resources
I.D.1.a)	There must be space and equipment for the educational program, including 24- hour computer access with Internet, classrooms with audiovisual and other educational aids, meeting rooms, and office space for residents. (Core)	1.8.a.	There must be space and equipment for hour computer access with Internet, clas educational aids, meeting rooms, and of
I.D.1.b)	There must be current information technology readily available for clinical care. (Core)	1.8.b.	There must be current information techn (Core)
I.D.1.c)	Each participating site must provide beds and operating time sufficient for the needs of the service and for resident education. (Core)	1.8.c.	Each participating site must provide beds needs of the service and for resident edu
I.D.1.d)	Residents must have access to outpatient facilities that provide clinics and office space for education in the regular pre-operative evaluation and postoperative follow-up of cases for which each resident has responsibility. (Core)	1.8.d.	Residents must have access to outpatier office space for education in the regular postoperative follow-up of cases for whic (Core)
I.D.1.e)	Technologically current equipment considered necessary for diagnosis and treatment must be available. (Core)	1.8.e.	Technologically current equipment consi treatment must be available. (Core)
I.D.1.f)	There should be clinical services in the related fields of anesthesiology, emergency medicine, internal medicine, neurological surgery, neurology, ophthalmology, pathology, pediatrics, and radiology. (Core)	1.8.f.	There should be clinical services in the re emergency medicine, internal medicine, ophthalmology, pathology, pediatrics, an
I.D.1.g)	There must be a variety of adult and pediatric medical and surgical patients available to allow development of resident competency in patient care. (Core)	1.8.g.	There must be a variety of adult and ped available to allow development of resider
I.D.2.	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:	1.9.	The program, in partnership with its S healthy and safe learning and working resident well-being and provide for:
I.D.2.a)	access to food while on duty; (Core)	1.9.a.	access to food while on duty; (Core)
I.D.2.b)	safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)	1.9.b.	safe, quiet, clean, and private sleep/re for residents with proximity appropria
I.D.2.c)	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	clean and private facilities for lactation with proximity appropriate for safe par
I.D.2.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures appropr (Core)
I.D.2.e)	accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)	1.9.e.	accommodations for residents with di Sponsoring Institution's policy. (Core)
I.D.3.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)	1.10.	Residents must have ready access to appropriate reference material in print include access to electronic medical l capabilities. (Core)
	Other Learners and Health Care Personnel The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the		Other Learners and Health Care Perso The presence of other learners and ot but not limited to residents from other and advanced practice providers, mus
I.E.	appointed residents' education. (Core)	1.11.	appointed residents' education. (Core
II.	Personnel	Section 2	Section 2: Personnel

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

or the educational program, including 24assrooms with audiovisual and other office space for residents. (Core)

nology readily available for clinical care.

ds and operating time sufficient for the ducation. (Core)

ent facilities that provide clinics and r pre-operative evaluation and nich each resident has responsibility.

sidered necessary for diagnosis and

related fields of anesthesiology, e, neurological surgery, neurology, and radiology. (Core)

ediatric medical and surgical patients ent competency in patient care. (Core)

Sponsoring Institution, must ensure ng environments that promote

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

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

priate to the participating site; and,

disabilities consistent with the re)

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

sonnel

other health care personnel, including, er programs, subspecialty fellows, ust not negatively impact the re)

Roman Numeral Requirement		Reformatted Requirement	
Number	Requirement Language	Number	Requirement
II.A.	Program Director	2.1.	Program Director There must be one faculty member ap authority and accountability for the ov with all applicable program requireme
			Program Director
II.A.1.	There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)	2.1.	There must be one faculty member ap authority and accountability for the ov with all applicable program requirement
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 m 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 director (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 reten length of time adequate to maintain co 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 applicat must be provided with support adequ based upon its size and configuration
	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: (Core)		At a minimum, the program director mus and support specified below for administ
II.A.2.a)	Number of Approved Resident Positions: 1-10 Minimum Support Required (FTE): 10% Number of Approved Resident Positions: 11 or more Minimum Support Required (FTE): 20%	2.4.a.	Number of Approved Resident Positions (FTE): 10% Number of Approved Resident Positions Required (FTE): 20%
II.A.3.	Qualifications of the program director:	2.5.	Qualifications of the Program Director The program director must possess s 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 s 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 Otolaryngology – Head and Neck Surgery (ABOHNS), or by the American Osteopathic Board of Ophthalmology and Otolaryngology – Head and Neck Surgery (AOBOO-HNS), or specialty qualifications that are acceptable to the Review Committee; (Core)	2.5.a.	The program director must possess of for which they are the program director Otolaryngology – Head and Neck Surger Osteopathic Board of Ophthalmology a Surgery (AOBOO-HNS), or specialty que the Review Committee. (Core)
	The Review Committee accepts only ABOHNS or AOBOO-HNS certification.		The Review Committee accepts only AB
II.A.3.b).(1)	(Core)	2.5.a.1.	(Core)
II.A.3.c)	must include ongoing clinical activity. (Core)	2.5.b.	The program director must demonstra
II.A.3.d)	must include evidence of periodic updates of knowledge and skills to discharge the roles and responsibilities for teaching, supervision, and formal evaluation of residents. (Core)	2.5.c.	The program director must demonstrate knowledge and skills to discharge the ro supervision, and formal evaluation of res

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

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

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

tor resides with the Review Committee.

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

able, the program's leadership team, juate for administration of the program on. (Core)

ust be provided with the dedicated time istration of the program: (Core)

ns: 1-10 | Minimum Support Required

ns: 11 or more | Minimum Support

or

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

or

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

current certification in the specialty ctor by the American Board of ery (ABOHNS), or by the American and Otolaryngology – Head and Neck qualifications that are acceptable to

BOHNS or AOBOO-HNS certification.

trate ongoing clinical activity. (Core)

te evidence of periodic updates of roles and responsibilities for teaching, esidents. (Core)

Roman Numeral		Reformatted Requirement	
Requirement Number	Requirement Language	Number	Requirement
	Program Director Responsibilities		
	Frogram 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 missio
			The program director must administer
	administer and maintain a learning environment conducive to educating		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		physicians and non-physicians as fac
	as faculty members at all participating sites, including the designation of		sites, including the designation of cor
	core faculty members, and must develop and oversee a process to		develop and oversee a process to eva
II.A.4.a).(4)	evaluate candidates prior to approval; (Core)	2.6.d.	(Core)
	have the authority to remove residents from supervising interactions		The program director must have the a
	and/or learning environments that do not meet the standards of the		supervising interactions and/or learning
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	2.0.0.	The program director must submit acc
II.A.4.a).(6)	DIO, GMEC, and ACGME; (Core)	2.6.f.	required and requested by the DIO, GI
	provide a learning and working environment in which residents have the	2.0	The program director must provide a
l	opportunity to raise concerns, report mistreatment, and provide feedback		which residents have the opportunity
	in a confidential manner as appropriate, without fear of intimidation or		mistreatment, and provide feedback in
II.A.4.a).(7)	retaliation; (Core)	2.6.g.	appropriate, without fear of intimidation
		2.0.9.	
	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including		The program director must ensure the Sponsoring Institution's policies and
	when action is taken to suspend or dismiss, or not to promote or renew		and due process, including when action
II.A.4.a).(8)	the appointment of a resident; (Core)	2.6.h.	not to promote or renew the appointm
II.A.4.a).(0)		2.0.11.	The program director must ensure the
	ensure the program's compliance with the Sponsoring Institution's		Sponsoring Institution's policies and
II.A.4.a).(9)	policies and procedures on employment and non-discrimination; (Core)	2.6.i.	discrimination. (Core)
II.A.4.a).(3)		2.0.1.	Residents must not be required to sig
II A A a) (9) (a)	Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	restrictive covenant. (Core)
II.A.4.a).(9).(a)		J. I.	,
	desument verification of education for all residents within 00 days of		The program director must document
	document verification of education for all residents within 30 days of	261	residents within 30 days of completion
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	2 G K	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 request
	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).	261	interview with information related to the
II.A.4.a).(12)	(Core)	2.6.I.	relevant specialty board examination(

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

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

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

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

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

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

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

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

ign a non-competition guarantee or

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

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

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

Roman Numeral Requirement		Reformatted Requirement	
Number	Requirement Language	Number	Requiremen
	Faculty		Faculty
	Faculty members are a foundational element of graduate medical		Faculty members are a foundational e
	education – faculty members teach residents how to care for patients.		education – faculty members teach re
	Faculty members provide an important bridge allowing residents to grow		Faculty members provide an importal
	and become practice-ready, ensuring that patients receive the highest		and become practice-ready, ensuring
	quality of care. They are role models for future generations of physicians		quality of care. They are role models
	by demonstrating compassion, commitment to excellence in teaching and		by demonstrating compassion, comn
	patient care, professionalism, and a dedication to lifelong learning.		patient care, professionalism, and a c
	Faculty members experience the pride and joy of fostering the growth and		Faculty members experience the prid
	development of future colleagues. The care they provide is enhanced by		development of future colleagues. Th
	the opportunity to teach and model exemplary behavior. By employing a		the opportunity to teach and model e
	scholarly approach to patient care, faculty members, through the		scholarly approach to patient care, fa
	graduate medical education system, improve the health of the individual		graduate medical education system,
	and the population.		and the population.
	Faculty members ensure that patients receive the level of care expected		Faculty members ensure that patients
	from a specialist in the field. They recognize and respond to the needs of		from a specialist in the field. They rec
	the patients, residents, community, and institution. Faculty members		the patients, residents, community, a
	provide appropriate levels of supervision to promote patient safety.		provide appropriate levels of supervis
	Faculty members create an effective learning environment by acting in a		Faculty members create an effective l
	professional manner and attending to the well-being of the residents and		professional manner and attending to
II.B.	themselves.	[None]	themselves.
	There must be a sufficient number of faculty members with competence to		There must be a sufficient number of
II.B.1.	instruct and supervise all residents. (Core)	2.7.	instruct and supervise all residents. (
II.B.1.a)	In addition to the program director, there should be at least two other FTE faculty members with qualifications to include: (Core)	2.7.a.	In addition to the program director, there faculty members with qualifications to in-
I.D. I.a)		Z.1.d.	
	specialty expertise and documented educational and administrative experience	07.01	specialty expertise and documented edu
II.B.1.a).(1)	acceptable to the Review Committee; and, (Core)	2.7.a.1.	acceptable to the Review Committee; ar
II.B.1.a).(2) II.B.2.	appropriate medical staff appointment. (Core) Faculty members must:	2.7.a.2. [None]	appropriate medical staff appointment. (
		[]	Faculty Responsibilities
II.B.2.a)	be role models of professionalism; (Core)	2.8.	Faculty members must be role model
,	demonstrate commitment to the delivery of safe, equitable, high-quality,		Faculty members must demonstrate of
II.B.2.b)	cost-effective, patient-centered care; (Core)	2.8.a.	equitable, high-quality, cost-effective
,	demonstrate a strong interest in the education of residents, including		Faculty members must demonstrate a
	devoting sufficient time to the educational program to fulfill their		residents, including devoting sufficie
II.B.2.c)	supervisory and teaching responsibilities; (Core)	2.8.b.	fulfill their supervisory and teaching i
,	administer and maintain an educational environment conducive to		Faculty members must administer an
II.B.2.d)	educating residents; (Core)	2.8.c.	environment conducive to educating
,	regularly participate in organized clinical discussions, rounds, journal		Faculty members must regularly parti
		2.8.d.	discussions, rounds, journal clubs, a
I.B.2.e)	Clubs, and conferences, and, (core)		· · · · ·
ll.B.2.e)	clubs, and conferences; and, (Core) pursue faculty development designed to enhance their skills at least		Faculty members must pursue faculty
-	pursue faculty development designed to enhance their skills at least	2.8.e.	
II.B.2.f)	pursue faculty development designed to enhance their skills at least annually: (Core)	2.8.e. 2.8.e.1.	their skills at least annually: (Core)
II.B.2.f)	pursue faculty development designed to enhance their skills at least annually: (Core) as educators and evaluators; (Detail)	2.8.e. 2.8.e.1.	their skills at least annually: (Core) as educators and evaluators; (Detail)
II.B.2.e) II.B.2.f) II.B.2.f).(1) II.B.2.f).(2)	pursue faculty development designed to enhance their skills at least annually: (Core)		Faculty members must pursue faculty their skills at least annually: (Core) as educators and evaluators; (Detail) in quality improvement, eliminating he (Detail)

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

Its receive the level of care expected ecognize and respond to the needs of and institution. Faculty members vision to promote patient safety. e learning environment by acting in a to the well-being of the residents and

of faculty members with competence to (Core)

re should be at least two other FTE include: (Core)

ducational and administrative experience and, (Core)

(Core)

els of professionalism. (Core)

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

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

nd maintain an educational g residents. (Core)

rticipate in organized clinical

and conferences. (Core)

Ity development designed to enhance

)

health inequities, and patient safety;

dents' well-being; and, (Detail)

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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.2.f).(5)	A faculty member serving as a local site director must have major clinical responsibilities at that site. (Core)	2.8.f.	A faculty member serving as a local site responsibilities at that site. (Core)
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 Otolaryngology – Head and Neck Surgery or the American Osteopathic Board of Ophthalmology and Otolaryngology – Head and Neck Surgery, or possess qualifications judged acceptable to the Review Committee. (Core)	2.10.	Physician faculty members must have by the American Board of Otolaryngold American Osteopathic Board of Ophth and Neck Surgery, or possess qualific Review Committee. (Core)
	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	2.44	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
II.B.4.	feedback to residents. (Core) Core faculty members must complete the annual ACGME Faculty Survey.	2.11.	feedback to residents. (Core) Core faculty members must complete
II.B.4.a)	(Core)	2.11.a.	(Core)
II.B.4.b)	There must be at least five core faculty members who are ABOHNS or AOBOO- HNS certified in otolaryngology – head and neck surgery. (Core)	2.11.b.	There must be at least five core faculty r HNS certified in otolaryngology – head a
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
II.C.2.a)	Number of Approved Resident Positions: 1-10 Minimum FTE: 50% Number of Approved Resident Positions: 11 or more Minimum FTE: 80%	2.12.b.	Number of Approved Resident Positions Number of Approved Resident Positions
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 S ensure the availability of necessary p administration of the program. (Core)
II.D.1.	This must include speech pathologists, audiologists, and/or balance therapists necessary for carrying out audiologic and vestibular testing and rehabilitation. (Core)	2.13.a.	This must include speech pathologists, a necessary for carrying out audiologic an (Core)

ent Language ce-based learning and improvement

te director must have major clinical

priate qualifications in their field and ntments. (Core)

priate qualifications in their field and ntments. (Core)

ve current certification in the specialty ology – Head and Neck Surgery or the othalmology and Otolaryngology – Head fications judged acceptable to the

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

te the annual ACGME Faculty Survey.

/ members who are ABOHNS or AOBOOl and neck surgery. (Core)

or. (Core)

or. (Core)

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

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

ns: 1-10 | Minimum FTE: 50% ns: 11 or more | Minimum FTE: 80%

Sponsoring Institution, must jointly personnel for the effective

, audiologists, and/or balance therapists and vestibular testing and rehabilitation.

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Requirement		Requirement	
Number	Requirement Language	Number	Requirement
III.	Resident Appointments	Section 3	Section 3: Resident Appointments
			Eligibility Requirements
			An applicant must meet one of the fol
II.A.	Eligibility Requirements	3.2.	for appointment to an ACGME-accred
			Eligibility Requirements
	An applicant must meet one of the following qualifications to be eligible		An applicant must meet one of the fol
III.A.1.	for appointment to an ACGME-accredited program: (Core)	3.2.	for appointment to an ACGME-accred
	graduation from a medical school in the United States, accredited by the		graduation from a medical school in t
	Liaison Committee on Medical Education (LCME) or graduation from a		Liaison Committee on Medical Educat
	college of osteopathic medicine in the United States, accredited by the		college of osteopathic medicine in the
	American Osteopathic Association Commission on Osteopathic College		American Osteopathic Association Co
III.A.1.a)	Accreditation (AOACOCA); or, (Core)	3.2.a.	Accreditation (AOACOCA); or, (Core)
			graduation from a medical school out
			meeting one of the following addition
			- holding o ourrontly volid cortificate f
			 holding a currently valid certificate f Foreign Medical Graduates (ECFMG)
			holding a full and unrestricted licens
	graduation from a medical school outside of the United States, and		States licensing jurisdiction in which
III.A.1.b)	meeting one of the following additional qualifications: (Core)	3.2.b.	located. (Core)
			graduation from a medical school out
			meeting one of the following addition
			 holding a currently valid certificate f
			Foreign Medical Graduates (ECFMG)
			 holding a full and unrestricted licens
	holding a currently valid certificate from the Educational Commission for		States licensing jurisdiction in which
III.A.1.b).(1)	Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)	3.2.b.	located. (Core)
- / \ - /		-	
			graduation from a medical school out meeting one of the following addition
			 holding a currently valid certificate f
			Foreign Medical Graduates (ECFMG)
			halding a full and some stated at 1
	holding a full and unrestricted license to practice medicine in the United		holding a full and unrestricted licens
	States licensing jurisdiction in which the ACGME-accredited program is	3.2 h	States licensing jurisdiction in which
III.A.1.b).(2)	located. (Core)	3.2.b.	located. (Core)

ollowing qualifications to be eligible edited program: (Core)

ollowing qualifications to be eligible edited program: (Core)

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

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

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

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

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

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

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

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

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

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

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III.A.2.	All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)- accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)	3.3.	All prerequisite post-graduate clinical or transfer into ACGME-accredited res completed in ACGME-accredited resid residency programs, Royal College of (RCPSC)-accredited or College of Fan accredited residency programs locate programs with ACGME International (Accreditation. (Core)
III.A.2.a)	Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)	3.3.a.	Residency programs must receive ver competency in the required clinical fie ACGME-I Milestones evaluations from matriculation. (Core)
	Resident Complement		
III.B.	The program director must not appoint more residents than approved by the Review Committee. (Core)	3.4.	Resident Complement The program director must not appoir the Review Committee. (Core)
III.B.1.	If a vacancy in a program's resident complement is filled, it should be filled at the same level in which it occurs. Exceptions must be approved by the Review Committee. (Core)	3.4.a.	If a vacancy in a program's resident com the same level in which it occurs. Except 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)
III.C.1.	The Review Committee for Otolaryngology – Head and Neck Surgery does not allow transfer into an ACGME-accredited otolaryngology – head and neck surgery program at the PGY-2 level or above from a RCPSC-accredited program. (Core)	3.5.a.	The Review Committee for Otolaryngolog allow transfer into an ACGME-accredited surgery program at the PGY-2 level or al program. (Core)
	Educational Program		Section 4: Educational Program
	The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.		The ACGME accreditation system is a and innovation in graduate medical ed organizational affiliation, size, or loca
	The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.		The educational program must suppo knowledgeable, skillful physicians wh
IV.	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	It is recognized programs may place of leadership, public health, etc. It is exp reflect the nuanced program-specific example, it is expected that a program scientists will have a different curricu community health.
IV.A.	Educational Components	4.2.	Educational Components The curriculum must contain the follo

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

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

bint more residents than approved by

omplement is filled, it should be filled at eptions must be approved by the Review

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

logy – Head and Neck Surgery does not ed otolaryngology – head and neck above from a RCPSC-accredited

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

port the development of who provide compassionate care.

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

lowing educational components:

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	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.	applicants, residents, and faculty members; (Core)	4.2.a.	applicants, residents, and faculty mer
	competency-based goals and objectives for each educational experience		competency-based goals and objectiv
	designed to promote progress on a trajectory to autonomous practice.		designed to promote progress on a tr
	These must be distributed, reviewed, and available to residents and		These must be distributed, reviewed,
V.A.2.	faculty members; (Core)	4.2.b.	faculty members; (Core)
11/ A 2	delineation of resident responsibilities for patient care, progressive	1.2 -	delineation of resident responsibilitie
IV.A.3.	responsibility for patient management, and graded supervision; (Core)	4.2.c.	responsibility for patient managemen
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured didactic a
	Decidents must be provided with protected time to participate in core		Didactic and Clinical Experiences
	Residents must be provided with protected time to participate in core	4.11.	Residents must be provided with prot
IV.A.4.a)	didactic activities. (Core) formal educational activities that promote patient safety-related goals,		didactic activities. (Core) formal educational activities that pror
IV.A.5.	tools, and techniques. (Core)	4.2.e.	tools, and techniques. (Core)
		4.2.6.	
			ACGME Competencies
			The Competencies provide a concept
			required domains for a trusted physic
			These Competencies are core to the p the specifics are further defined by ea
			trajectories in each of the Competence
IV.B.	ACGME Competencies	[None]	Milestones for each specialty.
	The program must integrate the following ACGME Competencies into the		
IV.B.1.	curriculum:	[None]	The program must integrate all ACGM
			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 competer
			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 compete
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 autono
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
V.B.1.a).(1).(f)	national origin, socioeconomic status, and sexual orientation; (Core)	4.3.f.	national origin, socioeconomic status
		1	ability to recognize and develop a pla
	applie to recognize and develop a plan for one's own personal and		
	ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)	4.3.g.	
IV.B.1.a).(1).(g)		4.3.g.	professional well-being; and, (Core) appropriately disclosing and address

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

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

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

otected time to participate in core

omote patient safety-related goals,

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

ME Competencies into the curriculum.

nalism nmitment to professionalism and an ore)

etence in:

alism mitment to professionalism and an re)

etence in:

for others; (Core)

at supersedes self-interest; (Core)

nomy; (Core)

and the profession; (Core)

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

ssing conflict or duality of interest.

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IV.B.1.b)	Patient Care and Procedural Skills	[None]	
	Residents must be able to provide patient care that is patient- and family- centered, compassionate, equitable, appropriate, and effective for the		ACGME Competencies – Patient Care Residents must be able to provide pa centered, compassionate, equitable, a
IV.B.1.b).(1)	treatment of health problems and the promotion of health. (Core)	4.4.	treatment of health problems and the
IV.B.1.b).(1).(a)	Residents must demonstrate competence in care that is: (Core)	[None]	
			Residents must demonstrate competenc
IV.B.1.b).(1).(a).(i)	culturally sensitive; (Core)	4.4.a.	(Core)
IV.B.1.b).(1).(a).(ii)	situationally sensitive; and, (Core)	4.4.b.	Residents must demonstrate competenc (Core)
IV.B.1.b).(1).(a).(iii)	specific to the particular patient's/family's needs. (Core)	4.4.c.	Residents must demonstrate competence patient's/family's needs. (Core)
IV.B.1.b).(1).(b)	Residents must demonstrate competence in formulating differential diagnoses of conditions affecting the head and neck; (Core)	4.4.d.	Residents must demonstrate competenc of conditions affecting the head and necl
IV.B.1.b).(1).(c)	Residents must demonstrate competence in care that is accurate in diagnosis and treatment care options. (Core)	4.4.e.	Residents must demonstrate competenc and treatment care options. (Core)
IV.B.1.b).(1).(d)	Residents must demonstrate competence in interpreting data and developing patient care plans for the following diagnostic procedures: (Core)	4.4.f.	Residents must demonstrate competenc patient care plans for the following diagn
IV.B.1.b).(1).(d).(i)	audiology testing; (Core)	4.4.f.1.	audiology testing; (Core)
IV.B.1.b).(1).(d).(ii)	histopathology studies; (Core)	4.4.f.2.	histopathology studies; (Core)
IV.B.1.b).(1).(d).(iii)	imaging studies of the head and neck; (Core)	4.4.f.3.	imaging studies of the head and neck; (C
IV.B.1.b).(1).(d).(iv)	laboratory testing; (Core)	4.4.f.4.	laboratory testing; (Core)
IV.B.1.b).(1).(d).(v)	sleep studies; (Core)	4.4.f.5.	sleep studies; (Core)
IV.B.1.b).(1).(d).(vi)	speech and voice testing; and, (Core)	4.4.f.6.	speech and voice testing; and, (Core)
IV.B.1.b).(1).(d).(vii)	vestibular testing. (Core)	4.4.f.7.	vestibular testing. (Core)
IV.B.1.b).(2)	Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)	4.5.	ACGME Competencies – Patient Care Residents must be able to perform all procedures considered essential for t
	Residents must demonstrate competence in performing and interpreting the		Residents must demonstrate competenc
IV.B.1.b).(2).(a)	data resulting from the following diagnostic procedures: (Core)	4.5.a.	data resulting from the following diagnos
IV.B.1.b).(2).(a).(i)	allergy testing; (Core)	4.5.a.1.	allergy testing; (Core)
IV.B.1.b).(2).(a).(ii)	clinical history and exam; (Core)	4.5.a.2.	clinical history and exam; (Core)
IV.B.1.b).(2).(a).(iii)	facial analysis; and, (Core)	4.5.a.3.	facial analysis; and, (Core)
IV.B.1.b).(2).(a).(iv)	smell and taste testing. (Core)	4.5.a.4.	smell and taste testing. (Core)
N = (2) (2)	Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head	4.5.b.	Residents must demonstrate competenc and non-surgical management and treat
IV.B.1.b).(2).(b)	and neck, including: (Core) aerodigestive foreign body obstruction; (Core)	4.5.b.1.	and neck, including: (Core) aerodigestive foreign body obstruction; (
IV.B.1.b).(2).(b).(i) IV.B.1.b).(2).(b).(ii)	allergic and immunologic disorders; (Core)	4.5.b.2.	allergic and immunologic disorders; (Cor
IV.B.1.b).(2).(b).(iii)	chemoreceptive disorders; (Core)	4.5.b.3.	chemoreceptive disorders; (Core)
IV.B.1.b).(2).(b).(iv)	voice, speech, and swallowing disorders; (Core)	4.5.b.4.	voice, speech, and swallowing disorders
IV.B.1.b).(2).(b).(v)	disorders related to the geriatric population; (Core)	4.5.b.5.	disorders related to the geriatric populati
IV.B.1.b).(2).(b).(vi)	endocrine disorders related to the thyroid and parathyroid; (Core)	4.5.b.6.	endocrine disorders related to the thyroid
IV.B.1.b).(2).(b).(vii)	facial plastic and reconstructive disorders; (Core)	4.5.b.7.	facial plastic and reconstructive disorders
		4.5.b.8.	idiopathic disorders (Core)
	Idiopathic disorders (Core)	4.5.0.0.	
IV.B.1.b).(2).(b).(viii) IV.B.1.b).(2).(b).(ix)	idiopathic disorders (Core) infectious and inflammatory disorders; (Core)	4.5.b.9.	infectious and inflammatory disorders; (C

re and Procedural Skills (Part A) patient care that is patient- and family-, appropriate, and effective for the le promotion of health. (Core)

nce in care that is culturally sensitive.

nce in care that is situationally sensitive.

nce in care that is specific to the particular

nce in formulating differential diagnoses eck. (Core)

nce in care that is accurate in diagnosis

nce in interpreting data and developing gnostic procedures: (Core)

(Core)

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

nce in performing and interpreting the ostic procedures: (Core)

nce in surgical (including peri-operative) atment of conditions affecting the head

; (Core) ore)

ers; (Core)

ation; (Core)

oid and parathyroid; (Core)

ers; (Core)

(Core)

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IV.B.1.b).(2).(b).(xi)	neoplastic disorders; (Core)	4.5.b.11.	neoplastic disorders; (Core)
IV.B.1.b).(2).(b).(xii)	neurologic disorders related to the head and neck; (Core)	4.5.b.12.	neurologic disorders related to the head
IV.B.1.b).(2).(b).(xiii)	pain; (Core)	4.5.b.13.	pain; (Core)
IV.B.1.b).(2).(b).(xiv)	pediatric and congenital disorders; (Core)	4.5.b.14.	pediatric and congenital disorders; (Core
IV.B.1.b).(2).(b).(xv)	sleep disorders; (Core)	4.5.b.15.	sleep disorders; (Core)
IV.B.1.b).(2).(b).(xvi)	traumatic disorders; (Core)	4.5.b.16.	traumatic disorders; (Core)
IV.B.1.b).(2).(b).(xvii)	vascular disorders; and, (Core)	4.5.b.17.	vascular disorders; and, (Core)
IV.B.1.b).(2).(b).(xviii)	vestibular and hearing disorders. (Core)	4.5.b.18.	vestibular and hearing disorders. (Core)
	Residents should demonstrate competence in performing otolaryngologic		Residents should demonstrate competer
IV.B.1.b).(2).(c)	procedures, including: (Core)	4.5.c.	procedures, including: (Core)
IV.B.1.b).(2).(c).(i)	airway management; (Core)	4.5.c.1.	airway management; (Core)
IV.B.1.b).(2).(c).(ii)	computer-assisted navigation; (Core)	4.5.c.2.	computer-assisted navigation; (Core)
IV.B.1.b).(2).(c).(iii)	endoscopy of the upper aerodigestive tract; (Core)	4.5.c.3.	endoscopy of the upper aerodigestive tra
IV.B.1.b).(2).(c).(iv)	laser usage; (Core)	4.5.c.4.	laser usage; (Core)
IV.B.1.b).(2).(c).(v)	local and regional anesthesia; (Core)	4.5.c.5.	local and regional anesthesia; (Core)
IV.B.1.b).(2).(c).(vi)	resuscitation; (Core)	4.5.c.6.	resuscitation; (Core)
IV.B.1.b).(2).(c).(vii)	stroboscopy; and, (Core)	4.5.c.7.	stroboscopy; and, (Core)
IV.B.1.b).(2).(c).(viii)	universal precautions. (Core)	4.5.c.8.	universal precautions. (Core)
IV.B.1.c)	Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)	4.6.	ACGME Competencies – Medical Kno Residents must demonstrate knowled biomedical, clinical, epidemiological, including scientific inquiry, as well as patient care. (Core)
IV.B.1.c).(1)	Residents must demonstrate knowledge appropriate for unsupervised practice of otolaryngology – head and neck surgery as defined by the ABOHNS curriculum. (Core)	4.6.a.	Residents must demonstrate knowledge of otolaryngology – head and neck surge curriculum. (Core)
IV.B.1.c).(2)	Residents must demonstrate knowledge of anatomy through procedural skills demonstrated in cadaver dissection, temporal bone lab, and/or surgical simulator labs. (Core)	4.6.b.	Residents must demonstrate knowledge demonstrated in cadaver dissection, tem simulator labs. (Core)
IV.B.1.d)	Practice-based Learning and Improvement Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning; (Core)	4.7.	ACGME Competencies – Practice-Bas Residents must demonstrate the abili care of patients, to appraise and assir continuously improve patient care bas lifelong learning. (Core)
IV.B.1.d).(1)	Residents must demonstrate competence in:	[None]	
	identifying strengths, deficiencies, and limits in one's knowledge and		Residents must demonstrate compete
IV.B.1.d).(1).(a)	expertise; (Core)	4.7.a.	deficiencies, and limits in one's know
			Residents must demonstrate compete
IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)	4.7.b.	improvement goals. (Core)
			Residents must demonstrate compete
IV.B.1.d).(1).(c)	identifying and performing appropriate learning activities; (Core)	4.7.c.	appropriate learning activities. (Core)
	systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and		Residents must demonstrate competer practice using quality improvement m reducing health care disparities, and i
IV.B.1.d).(1).(d)	implementing changes with the goal of practice improvement; (Core)	4.7.d.	of practice improvement. (Core)

ent Language d and neck; (Core) ore) tence in performing otolaryngologic tract; (Core) nowledge edge of established and evolving I, and social-behavioral sciences, as the application of this knowledge to ge appropriate for unsupervised practice gery as defined by the ABOHNS ge of anatomy through procedural skills emporal bone lab, and/or surgical ased Learning and Improvement ility to investigate and evaluate their similate scientific evidence, and to based on constant self-evaluation and etence in identifying strengths, wledge and expertise. (Core) etence in setting learning and etence in identifying and performing e) etence in systematically analyzing methods, including activities aimed at d implementing changes with the goal

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	incorporating feedback and formative evaluation into daily practice; and,		Residents must demonstrate compete
IV.B.1.d).(1).(e)	(Core)	4.7.e.	formative evaluation into daily practic
IV.B.1.d).(1).(f)	locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)	4.7.f.	Residents must demonstrate competer assimilating evidence from scientific s 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 – Interpersona Residents must demonstrate interpers result in the effective exchange of info patients, their families, and health pro
IV.B.1.e).(1)	Residents must demonstrate competence in:	[None]	
IV.B.1.e).(1).(a)	communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)	4.8.a.	Residents must demonstrate compete with patients and patients' families, as of socioeconomic circumstances, cul capabilities, learning to engage interp provide appropriate care to each patie
			Residents must demonstrate compete
IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; (Core)	4.8.b.	with physicians, other health professi (Core)
	working effectively as a member or leader of a health care team or other		Residents must demonstrate compete
IV.B.1.e).(1).(c)	professional group; (Core)	4.8.c.	member or leader of a health care tea
	educating patients, patients' families, students, other residents, and other	4.0.4	Residents must demonstrate compete
IV.B.1.e).(1).(d)	health professionals; (Core)	4.8.d.	families, students, other residents, an
IV.B.1.e).(1).(e)	acting in a consultative role to other physicians and health professionals; (Core)	4.8.e.	Residents must demonstrate competer to other physicians and health profes
14.0.1.0).(1).(0)	maintaining comprehensive, timely, and legible health care records, if	4.0.0.	Residents must demonstrate competer
IV.B.1.e).(1).(f)	applicable. (Core)	4.8.f.	timely, and legible health care records
	Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when		Residents must learn to communicate to partner with them to assess their care
IV.B.1.e).(2)	appropriate, end-of-life goals. (Core)	4.8.g.	appropriate, end-of-life goals. (Core)
IV.B.1.e).(3)	Residents must develop and present educational materials to the public. (Core)	4.8.h.	Residents must develop and present edu
	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		ACGME Competencies - Systems-Bas Residents must demonstrate an awar larger context and system of health ca social determinants of health, as well
IV.B.1.f)	other resources to provide optimal health care. (Core)	4.9.	other resources to provide optimal he
IV.B.1.f).(1)	Residents must demonstrate competence in:	[None]	
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 competer health care delivery settings and syste specialty. ^(Core)
IV.B.1.f).(1).(b)	coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)	4.9.b.	Residents must demonstrate competer across the health care continuum and specialty. ^(Core)

etence in incorporating feedback and ice. (Core)

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

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

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

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

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

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

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

ducational materials to the public. (Core)

ased Practice

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

etence in working effectively in various stems relevant to their clinical

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
	advocating for quality patient care and optimal patient care systems;		Residents must demonstrate compete
IV.B.1.f).(1).(c)	(Core)	4.9.c.	care and optimal patient care systems
IV.B.1.f).(1).(d)	participating in identifying system errors and implementing potential systems solutions; (Core)	4.9.d.	Residents must demonstrate compete system errors and implementing poter
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 compete of value, equity, cost awareness, deliv analysis in patient and/or population-b
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 compete finances and its impact on individual p
ТФ.В.Т.1).(Т).(Т)		4.5.1.	Residents must demonstrate compete
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.	that promote patient safety and disclo simulated). ^(Detail)
	Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals,		Residents must learn to advocate for p system to achieve the patient's and pa
IV.B.1.f).(2)	including, when appropriate, end-of-life goals. (Core)	4.9.h.	including, when appropriate, end-of-lif
IV.C.	Curriculum Organization and Resident Experiences	4.10 4.12.	Curriculum Organization and Resident 4.10. Curriculum Structure The curriculum must be structured to experiences, the length of the experience continuity. These educational experience supervised patient care responsibilitie educational events. (Core) 4.11. Didactic and Clinical Experience Residents must be provided with protodidactic activities. (Core) 4.12. Pain Management The program must provide instruction management if applicable for the spector signs of substance use disorder. (Core)
IV.C.1.	The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)	4.10.	The curriculum must be structured to experiences, the length of the experiences continuity. These educational experiences supervised patient care responsibilities educational events. (Core)
			Clinical rotations during the PGY-2-5 sho
IV.C.1.a)	must be at least four weeks in length. (Core)	4.10.a.	must be at least four weeks in length. (Co
IV.C.2.	The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)	4.12.	Pain Management The program must provide instruction management if applicable for the spec signs of substance use disorder. (Core
IV.C.1.a) IV.C.2.	Clinical rotations during the PGY-2-5 should be at least six weeks in length, and must be at least four weeks in length. (Core) The program must provide instruction and experience in pain		

etence in advocating for quality patient ns. (Core)

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

etence in incorporating considerations livery and payment, and risk-benefit n-based care as appropriate. (Core) etence in understanding health care al patients' health decisions. (Core) etence in using tools and techniques closure of patient safety events (real or

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

ent Experiences

to optimize resident educational iences, and the supervisory iences include an appropriate blend of ties, clinical teaching, and didactic

ces

otected time to participate in core

on and experience in pain ecialty, including recognition of the ore)

to optimize resident educational riences, and the supervisory riences include an appropriate blend of ities, clinical teaching, and didactic

hould be at least six weeks in length, and (Core)

on and experience in pain ecialty, including recognition of the ore)

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IV.C.3.	PGY-1 residents must participate in clinical and didactic activities in which they: (Core)	[None]	
IV.C.3.a)	assess, plan, and initiate treatment of adult and pediatric patients with surgical and/or medical problems; (Core)	4.11.a.	PGY-1 residents must participate in clin assess, plan, and initiate treatment of a and/or medical problems; (Core)
IV.C.3.b)	care for patients of all ages with surgical and medical emergencies, multiple organ system trauma, soft tissue wounds, nervous system injuries and diseases, and peripheral vascular and thoracic injuries; (Core)	4.11.b.	PGY-1 residents must participate in clinic care for patients of all ages with surgica organ system trauma, soft tissue wound diseases, and peripheral vascular and th
IV.C.3.c)	care for critically ill surgical and medical patients in the intensive care unit and emergency room settings; (Core)	4.11.c.	PGY-1 residents must participate in clinicare for critically ill surgical and medical emergency room settings; (Core)
IV.C.3.d)	participate in the pre-, intra-, and post-operative care of surgical patients; and, (Core)	4.11.d.	PGY-1 residents must participate in clini participate in the pre-, intra-, and post-o (Core)
IV.C.3.e)	participate in surgical anesthesia in hospital and ambulatory care settings, including evaluation of anesthetic risks and the management of intra-operative anesthetic complications. (Core)	4.11.e.	PGY-1 residents must participate in clini participate in surgical anesthesia in hosp including evaluation of anesthetic risks a anesthetic complications. (Core)
IV.C.4.	The PGY-1 must include:	[None]	
IV.C.4.a)	six months of structured education on non-otolaryngology – head and neck surgery rotations designed to foster development of competence in the peri- operative care of surgical patients, inter-disciplinary care coordination, and airway management skills; and, (Core)	4.11.f.	The PGY-1 must include six months of s otolaryngology – head and neck surgery development of competence in the peri- disciplinary care coordination, and airwa
IV.C.4.a).(1)	The total time a resident is assigned to any one non-otolaryngology – head and neck surgery rotation must be at least four weeks and must not exceed two months. (Core)	4.11.f.1.	The total time a resident is assigned to a neck surgery rotation must be at least for months. (Core)
IV.C.4.a).(2)	Rotations must be selected from the following: anesthesia; emergency medicine; general surgery; neurological surgery; neuroradiology; ophthalmology; oral-maxillofacial surgery; pediatric surgery; plastic surgery; radiation oncology; and vascular surgery. (Core)	4.11.f.2.	Rotations must be selected from the follomedicine; general surgery; neurological ophthalmology; oral-maxillofacial surger radiation oncology; and vascular surgery
IV.C.4.a).(2).(a)	This must include a surgical or medical intensive care rotation. (Core)	4.11.f.2.a.	This must include a surgical or medical
IV.C.4.a).(2).(b)	A one month or four-week night float rotation is permitted but must have structured educational goals and objectives, and the resident must be evaluated during and at the end of the rotation. (Core)	4.11.f.2.b.	A one month or four-week night float rota structured educational goals and objecti during and at the end of the rotation. (Co
	six months of otolaryngology – head and neck surgery rotations designed to develop competence in basic surgical skills, general care of otolaryngology – head and neck surgery patients both in the inpatient setting and in the outpatient clinics, management of otolaryngology – head and neck surgery patients in the emergency department, and cultivation of an otolaryngology –		The PGY-1 must include six months of c rotations designed to develop competen of otolaryngology – head and neck surge and in the outpatient clinics, management surgery patients in the emergency depart
IV.C.4.b)	head and neck surgery knowledge base. (Core)	4.11.g.	otolaryngology – head and neck surgery
IV.C.5.	The PGY-2-5 must include 48 months of progressive education in otolaryngology – head and neck surgery. (Core)	4.11.h.	The PGY-2-5 must include 48 months of otolaryngology – head and neck surgery
IV.C.6.	Each resident must spend a 12-month period as chief resident on the otolaryngology – head and neck surgery clinical service at the primary clinical site or one of the participating sites of the Sponsoring Institution during the last 24 months of the educational program. (Core)	4.11.i.	Each resident must spend a 12-month p otolaryngology – head and neck surgery site or one of the participating sites of th 24 months of the educational program. (
10.0.0.		7.11.1.	2 + 1101113 or the educational program.

nical and didactic activities in which they adult and pediatric patients with surgical

nical and didactic activities in which they al and medical emergencies, multiple ids, nervous system injuries and thoracic injuries; (Core)

nical and didactic activities in which they al patients in the intensive care unit and

nical and didactic activities in which they operative care of surgical patients; and,

nical and didactic activities in which they spital and ambulatory care settings, and the management of intra-operative

f structured education on nonry rotations designed to foster i-operative care of surgical patients, intervay management skills. (Core)

any one non-otolaryngology – head and four weeks and must not exceed two

ollowing: anesthesia; emergency al surgery; neuroradiology; ery; pediatric surgery; plastic surgery; ery. (Core)

l intensive care rotation. (Core)

otation is permitted but must have ctives, and the resident must be evaluated Core)

f otolaryngology – head and neck surgery ence in basic surgical skills, general care gery patients both in the inpatient setting nent of otolaryngology – head and neck partment, and cultivation of an ery knowledge base. (Core)

of progressive education in ry. (Core)

period as chief resident on the ry clinical service at the primary clinical the Sponsoring Institution during the last . (Core)

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IV.C.7.	The educational program must provide at least three months of a structured research experience for residents. (Core)	4.11.j.	The educational program must provide a research experience for residents. (Core
IV.C.7.a)	While the three-month research experience need not be contiguous, each research rotation should not be less than one month in length. (Core)	4.11.j.1.	While the three-month research experien research rotation should not be less than
IV.C.7.a).(1)	Programs seeking to design a research curriculum with dedicated research experiences less than one month in length must first obtain approval from the Review Committee. (Core)	4.11.j.1.a.	Programs seeking to design a research experiences less than one month in leng Review Committee. (Core)
IV.C.7.b)	The primary focus of this experience must be research and not clinical service or education. (Core)	4.11.j.2.	The primary focus of this experience mu or education. (Core)
IV.C.7.b).(1)	Concurrent clinical responsibilities must be limited. (Core)	4.11.j.2.a.	Concurrent clinical responsibilities must
IV.C.7.c)	The research experience must include instruction in research methods and design, as well as outcome assessment. (Core)	4.11.j.3.	The research experience must include ir design, as well as outcome assessment.
IV.C.8.	The didactic curriculum must include cyclical presentation of core specialty knowledge supplemented by the addition of breakthrough information. (Core)	4.11.k.	The didactic curriculum must include cyc knowledge supplemented by the addition
IV.C.9.	Educational conferences must include grand rounds, quality improvement conferences, morbidity and mortality conferences, and tumor conferences. (Core)	4.11.l.	Educational conferences must include g conferences, morbidity and mortality cor (Core)
IV.C.9.a)	Faculty members must participate in the preparation and presentation of educational conferences. (Core)	4.11.1.1.	Faculty members must participate in the educational conferences. (Core)
IV.C.9.b)	Residents must attend educational conferences. (Core)	4.11.1.2.	Residents must attend educational confe
IV.C.9.b).(1)	Each resident should attend at least 75 percent of the scheduled and held educational conferences. (Core)	4.11.l.2.a.	Each resident should attend at least 75 geodesic educational conferences. (Core)
IV.C.9.b).(2)	Educational conferences must be evaluated. (Core)	4.11.I.2.b.	Educational conferences must be evaluated
IV.C.9.c)	Didactic topics must include: basic sciences as relevant to the head and neck and upper-aerodigestive system; allergy and immunology; anatomy; biochemistry; cell biology; the communication sciences, including audiology, speech and language pathology, and the voice sciences, as they relate to laryngology; embryology; genetics; microbiology; pathology; pharmacology; physiology; rhinology; and the chemical senses, endocrinology, and neurology, as they relate to the head and neck. (Core)	4.11.1.3.	Didactic topics must include: basic scien and upper-aerodigestive system; allergy biochemistry; cell biology; the communic speech and language pathology, and the laryngology; embryology; genetics; micro physiology; rhinology; and the chemical as they relate to the head and neck. (Co
IV.C.9.c).(1)	Anatomy should include the study and dissection of anatomic specimens, including the temporal bone, and procedural skills laboratories, along with appropriate lectures and other formal sessions. (Detail)	4.11.I.3.a.	Anatomy should include the study and d including the temporal bone, and proced appropriate lectures and other formal se
IV.C.9.c).(2)	Pathology should include formal instruction in correlative pathology, including gross and microscopic pathology relating to the head and neck. (Detail)	4.11.l.3.b.	Pathology should include formal instruct gross and microscopic pathology relating
IV.C.9.c).(2).(a)	Residents should study and discuss with the pathology service tissues removed at operations and autopsy material. (Detail)	4.11.I.3.b.1.	Residents should study and discuss with at operations and autopsy material. (Det
IV.C.10.	Resident Supervision and Patient Care Experiences	4.11.m.	Resident Supervision and Patient Care E Residents must have experience with sta technology in otolaryngology – head and
IV.C.10.a)	Residents must have experience with state-of-the-art advances and emerging technology in otolaryngology – head and neck surgery. (Core)	4.11.m.	Resident Supervision and Patient Care E Residents must have experience with sta technology in otolaryngology – head and
IV.C.10.b)	Residents must perform a sufficient number, variety, and complexity of surgical procedures to ensure education in the entire scope of the specialty. (Core)	4.11.m.1.	Residents must perform a sufficient num procedures to ensure education in the e
IV.C.10.b).(1)	Residents must have essentially equivalent distributions of case categories and procedures. (Core)	4.11.m.1.a.	Residents must have essentially equival procedures. (Core)

at least three months of a structured re)

ence need not be contiguous, each an one month in length. (Core)

h curriculum with dedicated research ngth must first obtain approval from the

nust be research and not clinical service

t be limited. (Core)

instruction in research methods and nt. (Core)

yclical presentation of core specialty ion of breakthrough information. (Core)

grand rounds, quality improvement onferences, and tumor conferences.

ne preparation and presentation of

ferences. (Core)

5 percent of the scheduled and held

uated. (Core)

ences as relevant to the head and neck gy and immunology; anatomy; nication sciences, including audiology, he voice sciences, as they relate to crobiology; pathology; pharmacology; al senses, endocrinology, and neurology, Core) dissection of anatomic specimens, edural skills laboratories, along with

essions. (Detail)

ction in correlative pathology, including ing to the head and neck. (Detail)

ith the pathology service tissues removed etail)

Experiences

state-of-the-art advances and emerging nd neck surgery. (Core)

Experiences

state-of-the-art advances and emerging nd neck surgery. (Core)

mber, variety, and complexity of surgical entire scope of the specialty. (Core)

alent distributions of case categories and

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IV.C.10.c)	Residents must have a broad range of experience in otolaryngology – head and neck surgery through outpatient care. This must include: (Core)	4.11.m.2.	Residents must have a broad range of e neck surgery through outpatient care. The surgery through outpatient care.
IV.C.10.c).(1)	exposure to clinical aspects of diagnosis, medical and/or surgical therapy, and prevention of and rehabilitation from diseases, neoplasms, deformities, disorders, and/or injuries of the ears, upper respiratory and upper alimentary systems, face, jaws, and other head and neck systems; to head and neck oncology; and to facial plastic and reconstructive surgery; (Core)	4.11.m.2.a.	exposure to clinical aspects of diagnosis prevention of and rehabilitation from dise disorders, and/or injuries of the ears, up systems, face, jaws, and other head and oncology; and to facial plastic and recon
IV.C.10.c).(2)	evaluating patients, establishing provisional diagnoses, and initiating preliminary treatment plans; and, (Core)	4.11.m.2.b.	evaluating patients, establishing provision treatment plans; and, (Core)
IV.C.10.c).(3)	providing follow-up care and evaluating the results of surgical care. (Core)	4.11.m.2.c.	providing follow-up care and evaluating t
IV.C.10.d)	Residents should have experience in the management of office practice. (Detail)	4.11.m.3.	Residents should have experience in the
IV.C.10.e)	Residents must have experience in the emergency care of critically ill and injured patients with otolaryngologic conditions. (Core)	4.11.m.4.	Residents must have experience in the e injured patients with otolaryngologic con
IV.C.10.f)	Each resident must have patient care responsibility commensurate with his or her knowledge, problem-solving ability, manual skills, and experience, as well as with the severity and complexity of each patient's status. (Core)	4.11.m.5.	Each resident must have patient care resident knowledge, problem-solving ability, ras with the severity and complexity of ea
IV.C.10.f).(1)	This must include experience as assistant surgeon and resident supervisor. (Core)	4.11.m.5.a.	This must include experience as assista (Core)
IV.C.10.f).(2)	All levels of surgical intervention must be recorded in the ACGME Case Log System. (Core)	4.11.m.5.b.	All levels of surgical intervention must be System. (Core)
IV.C.11.	International Rotations	4.11.n.	International Rotations International rotations must be approved
IV.C.11.a)	International rotations must be approved by the program director. (Core)	4.11.n.	International Rotations International rotations must be approved
IV.C.11.b)	The total time spent in international rotations should be no more than one month over the five-year program. (Detail)	4.11.n.1.	The total time spent in international rotat over the five-year program. (Detail)
IV.C.11.c)	All institutional policies and procedures that govern the program at the sponsoring institution must continue to be in effect for residents during an international rotation. (Core)	4.11.n.2.	All institutional policies and procedures t sponsoring institution must continue to b international rotation. (Core)
IV.C.11.d)	Surgical procedures completed during an international rotation must not be counted toward meeting the required minima of procedures. (Core)	4.11.n.3.	Surgical procedures completed during an counted toward meeting the required min

⁻ experience in otolaryngology – head and This must include: (Core)

sis, medical and/or surgical therapy, and iseases, neoplasms, deformities, upper respiratory and upper alimentary nd neck systems; to head and neck onstructive surgery; (Core)

sional diagnoses, and initiating preliminary

5

g the results of surgical care. (Core)

he management of office practice. (Detail) e emergency care of critically ill and onditions. (Core)

responsibility commensurate with his or , manual skills, and experience, as well each patient's status. (Core)

tant surgeon and resident supervisor.

be recorded in the ACGME Case Log

ed by the program director. (Core)

ed by the program director. (Core) ations should be no more than one month

s that govern the program at the be in effect for residents during an

an international rotation must not be ninima of procedures. (Core)

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Number	Requirement Language	Number	Requirement
	Scholarship		
	Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.		Scholarship Medicine is both an art and a science scientist who cares for patients. This evaluate the literature, appropriately a practice lifelong learning. The progra environment that fosters the acquisit participation in scholarly activities. So discovery, integration, application, ar
IV.D.	The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.	[None]	The ACGME recognizes the diversity programs prepare physicians for a va scientists, and educators. It is expect will reflect its mission(s) and aims, an serves. For example, some programs activity on quality improvement, popu other programs might choose to utiliz research as the focus for scholarship
			Program Responsibilities
IV.D.1.	Program Responsibilities	4.13.	The program must demonstrate evide with its mission(s) and aims. (Core)
IV.D.1.a)	The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)	4.13.	Program Responsibilities The program must demonstrate evide with its mission(s) and aims. (Core)
IV.D.1.b)	The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)	4.13.a.	The program, in partnership with its adequate resources to facilitate reside scholarly activities. (Core)
IV.D.1.c)	The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)	4.13.b.	The program must advance residents scholarly approach to evidence-based
			Faculty Scholarly Activity Among their scholarly activity, progra accomplishments in at least three of t
			 Research in basic science, educatio or population health Peer-reviewed grants Quality improvement and/or patient
			 Systematic reviews, meta-analyses, textbooks, or case reports Creation of curricula, evaluation too electronic educational materials Contribution to professional commit editorial boards
IV.D.2.	Faculty Scholarly Activity	4.14.	 Innovations in education

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

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

dence of scholarly activities consistent

dence of scholarly activities consistent

s Sponsoring Institution, must allocate ident and faculty involvement in

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

rams must demonstrate f the following domains: (Core)

ion, translational science, patient care,

nt safety initiatives s, review articles, chapters in medical

ools, didactic educational activities, or

nittees, educational organizations, or

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
	Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)		Faculty Scholarly Activity Among their scholarly activity, progra accomplishments in at least three of t
	 Research in basic science, education, translational science, patient care, or population health Peer-reviewed grants 		 Research in basic science, education or population health Peer-reviewed grants
	 Quality improvement and/or patient safety initiatives Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports 		 Quality improvement and/or patient s Systematic reviews, meta-analyses, textbooks, or case reports
	 Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials Contribution to professional committees, educational organizations, or editorial boards 		 Creation of curricula, evaluation tool electronic educational materials Contribution to professional commit editorial boards
IV.D.2.a)	Innovations in education	4.14.	Innovations in education
			The program must demonstrate disser and external to the program by the fol • faculty participation in grand rounds improvement presentations, podium p peer-reviewed print/electronic resource chapters, textbooks, webinars, service serving as a journal reviewer, journal of (Outcome)
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.	peer-reviewed publication. (Outcome
,	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		The program must demonstrate disses and external to the program by the fol • faculty participation in grand rounds improvement presentations, podium p peer-reviewed print/electronic resource chapters, textbooks, webinars, service serving as a journal reviewer, journal (Outcome)
IV.D.2.b).(1)	serving as a journal reviewer, journal editorial board member, or editor; (Outcome)	4.14.a.	 peer-reviewed publication. (Outcome

rams must demonstrate f the following domains: (Core)

ion, translational science, patient care,

t safety initiatives s, review articles, chapters in medical

ools, didactic educational activities, or

nittees, educational organizations, or

semination of scholarly activity within following methods:

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

me)

semination of scholarly activity within following methods:

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

me)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
			The program must demonstrate disse and external to the program by the fo
			• faculty participation in grand round improvement presentations, podium peer-reviewed print/electronic resour chapters, textbooks, webinars, servic serving as a journal reviewer, journal (Outcome)
IV.D.2.b).(2)	peer-reviewed publication. (Outcome)	4.14.a.	peer-reviewed publication. (Outcon
IV.D.3.	Resident Scholarly Activity	4.15.	Resident Scholarly Activity Residents must participate in scholar
IV.D.3.a)	Residents must participate in scholarship. (Core)	4.15.	Resident Scholarly Activity Residents must participate in scholar
IV.D.3.a).(1)	The research experience (Program Requirement IV.C.7) should result in a completed manuscript suitable for publication in a peer-reviewed journal. (Outcome)	4.15.a.	The research experience (Program Requestion completed manuscript suitable for public (Outcome)
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 4	Feedback and Evaluation	F 4	Resident Evaluation: Feedback and E Faculty members must directly obser feedback on resident performance du
V.A.1.	Feedback and Evaluation	5.1.	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 the must be documented at least every the
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 eval 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)		The program must provide an objection the Competencies and the specialty-s
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 evalu patients, self, and other professional
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 progre improvement toward unsupervised pr

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)

larship. (Core)

arship. (Core)

equirement IV.C.7) should result in a plication in a peer-reviewed journal.

Evaluation

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

Evaluation

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

Evaluation

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

the completion of the assignment.

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 y-specific Milestones. ^(Core)

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

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
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 designe Competency Committee, must meet w their documented semi-annual evalua progress along the specialty-specific
V.A.1.d).(1).(a)	This must include review of the resident's cumulative operative experience at least semiannually to ensure balanced progress towards achieving experience with a variety and complexity of surgical procedures. (Core)	5.1.c.1.	This must include review of the resident' least semiannually to ensure balanced p with a variety and complexity of surgical
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 designe Competency Committee, must assist individualized learning plans to capita 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 designe Competency Committee, must develo progress, 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 sun that includes their readiness to progre applicable. (Core)
V.A.1.e).(1)	Residents must participate in existing national examinations. (Core)	5.1.f.1.	Residents must participate in existing na
V.A.1.e).(1).(a)	Use of the annual Otolaryngology – Head and Neck Surgery Training Examination is strongly suggested.	5.1.f.1.a.	Use of the annual Otolaryngology – Hea Examination is strongly suggested.
V.A.1.e).(1).(b)	An analysis of the results of these testing programs must be limited to guiding faculty members in assessing the strengths and weaknesses of the program and individual residents. (Core)	5.1.f.1.b.	An analysis of the results of these testing faculty members in assessing the streng and individual residents. (Core)
V.A.1.e).(2)	The faculty must meet annually to provide collective evaluation of each resident, including surgical competence, and must provide an annual summative report for each resident. (Core)	5.1.f.2.	The faculty must meet annually to provid including surgical competence, and mus for each resident. (Core)
	The evaluations of a resident's performance must be accessible for review		The evaluations of a resident's perfor
V.A.1.f)	by the resident. (Core)	5.1.g.	by the resident. (Core)
V.A.2.	Final Evaluation	5.2.	Resident Evaluation: Final Evaluation The program director must provide a upon completion of the program. (Con
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. (Con
V.A.2.a).(1)	The specialty-specific Milestones, and when applicable the specialty- specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)	5.2.a.	The specialty-specific Milestones, and specific Case Logs, must be used as engage in autonomous practice upon
V.A.2.a).(2)	The final evaluation must:	[None]	
V.A.2.a).(2).(a)	become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)	5.2.b.	The final evaluation must become par maintained by the institution, and must resident in accordance with institution

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

nt's cumulative operative experience at progress towards achieving experience al procedures. (Core)

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

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

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

national examinations. (Core) ead and Neck Surgery Training

ing programs must be limited to guiding ngths and weaknesses of the program

vide collective evaluation of each resident, ust provide an annual summative report

ormance must be accessible for review

on

a final evaluation for each resident core)

on

a final evaluation for each resident core)

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

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
V.A.2.a).(2).(b)	verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	The final evaluation must verify that the knowledge, skills, and behaviors nece (Core)
V.A.2.a).(2).(c)	be shared with the resident upon completion of the program. (Core)	5.2.d.	The final evaluation must be shared w the program. (Core)
V.A.3.	A Clinical Competency Committee must be appointed by the program director. (Core)	5.3.	Clinical Competency Committee A Clinical Competency Committee mu director. (Core)
V.A.3.a)	At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)	5.3.a.	At a minimum, the Clinical Competend members of the program faculty, at lea member. (Core)
V.A.3.a).(1)	Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)	5.3.b.	Additional members must be faculty n other programs, or other health profes and experience with the program's res
V.A.3.b)	The Clinical Competency Committee must:	[None]	
V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)	5.3.c.	The Clinical Competency Committee r at least semi-annually. (Core)
V.A.3.b).(2)	determine each resident's progress on achievement of the specialty- specific Milestones; and, (Core)	5.3.d.	The Clinical Competency Committee r progress on achievement of the speci
V.A.3.b).(3)	meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)	5.3.e.	The Clinical Competency Committee r semi-annual evaluations and advise th resident's progress. (Core)
V.B.	Faculty Evaluation	5.4.	Faculty Evaluation The program must have a process to performance as it relates to the educa (Core)
V.B.1.	The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)	5.4.	Faculty Evaluation The program must have a process to performance as it relates to the educa (Core)
V.B.1.a)	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)	5.4.a.	This evaluation must include a review teaching abilities, engagement with th in faculty development related to their performance, professionalism, and sc
V.B.1.b)	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)	5.4.b.	This evaluation must include written, evaluations by the residents. (Core)
V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feedba annually. (Core)
V.B.3.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)	5.4.d.	Results of the faculty educational eva program-wide faculty development pla
V.C.	Program Evaluation and Improvement	5.5.	Program Evaluation and Improvement The program director must appoint th conduct and document the Annual Pro program's continuous improvement p

the resident has demonstrated the cessary to enter autonomous practice.

with the resident upon completion of

nust be appointed by the program

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

/ members from the same program or fessionals 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' the program director regarding each

o evaluate each faculty member's cational program at least annually.

o evaluate each faculty member's cational program at least annually.

ew of the faculty member's clinical the educational program, participation eir 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 process. (Core)

Roman Numeral Requirement		Reformatted Requirement	
Number	Requirement Language	Number	Requirement La
	The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the		Program Evaluation and Improvement The program director must appoint the F conduct and document the Annual Prog
V.C.1.	program's continuous improvement process. (Core)	5.5.	program's continuous improvement proc
V.C.1.a)	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)	5.5.a.	The Program Evaluation Committee mus program faculty members, at least one o 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 response program's self-determined goals and pro
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 responsions ongoing program improvement, includin 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 responsi current operating environment to identify opportunities, and threats as related to t (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 sho prior Annual Program Evaluation(s), agg evaluations of the program, and other re 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 mus and aims, strengths, areas for improvem
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, includin distributed to and discussed with the res teaching faculty, and be submitted to the
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
	One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.		Board Certification One goal of ACGME-accredited educatio seek and achieve board certification. On the educational program is the ultimate
V.C.3.	The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.	[None]	The program director should encourage take the certifying examination offered b of Medical Specialties (ABMS) member b 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 members board offer(s) an annual written exam, in program's aggregate pass rate of those time must be higher than the bottom fifth specialty. (Outcome)

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

must be composed of at least two one of whom is a core faculty member,

oonsibilities must include review of the d progress toward meeting them. ^(Core) oonsibilities must include guiding luding development of new goals,

oonsibilities must include review of the entify strengths, challenges, d to the program's mission and aims.

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

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

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

cation is to educate physicians who

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

rage all eligible program graduates to red by the applicable American Board ber board or American Osteopathic

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

Roman Numeral Requirement		Reformatted Requirement	
Number	Requirement Language	Number	Requiremen
V.C.3.b)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.a.	For specialties in which the ABMS me board offer(s) a biennial written exam program's aggregate pass rate of tho time must be higher than the bottom specialty. ^(Outcome)
V.C.3.c)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.b.	For specialties in which the ABMS me board offer(s) an annual oral exam, in program's aggregate pass rate of tho time must be higher than the bottom specialty. ^(Outcome)
V.C.3.d)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.c.	For specialties in which the ABMS me board offer(s) a biennial oral exam, in program's aggregate pass rate of tho time must be higher than the bottom specialty. ^(Outcome)
	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 s graduates over the time period specif an 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 pas
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 tha
			Section 6: The Learning and Working
	The Learning and Working Environment		The Learning and Working Environme
	Residency education must occur in the context of a learning and working environment that emphasizes the following principles:		Residency education must occur in the environment that emphasizes the following the fo
	 Excellence in the safety and quality of care rendered to patients by residents today 		• Excellence in the safety and quality residents today
	• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice		• Excellence in the safety and quality today's residents in their future pract
	• Excellence in professionalism		• Excellence in professionalism
	• Appreciation for the privilege of caring for patients		• Appreciation for the privilege of car
	 Commitment to the well-being of the students, residents, faculty 		• Commitment to the well-being of the
VI.	members, and all members of the health care team	Section 6	members, and all members of the hea
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]	

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

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

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

a 5.6.a.-c., any program whose cified in the requirement have achieved et this requirement, no matter the ass rate in that specialty. ^(Outcome)

rd certification status annually for the nat graduated seven years earlier. ^(Core)

g Environment

nent

the context of a learning and working blowing principles:

y of care rendered to patients by

y of care rendered to patients by ctice

nring for patients

he students, residents, faculty ealth care team

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Requirement		Requirement	
Number	Requirement Language	Number	Requirement
	Culture of Safety		
			Culture of Safety
	A culture of safety requires continuous identification of vulnerabilities		A culture of safety requires continuou
	and a willingness to transparently deal with them. An effective		and a willingness to transparently dea
	organization has formal mechanisms to assess the knowledge, skills, and		organization has formal mechanisms
	attitudes of its personnel toward safety in order to identify areas for		attitudes of its personnel toward safet
VI.A.1.a).(1)	improvement.	[None]	improvement.
	The program, its faculty, residents, and fellows must actively participate in		The program, its faculty, residents, an
VI.A.1.a).(1).(a)	patient safety systems and contribute to a culture of safety. (Core)	6.1.	patient safety systems and contribute
	Patient Safety Events		
			Patient Safety Events
	Reporting, investigation, and follow-up of safety events, near misses, and		Reporting, investigation, and follow-u
	unsafe conditions are pivotal mechanisms for improving patient safety,		unsafe conditions are pivotal mechan
	and are essential for the success of any patient safety program. Feedback		and are essential for the success of an
	and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based		and experiential learning are essential the ability to identify causes and instit
VI.A.1.a).(2)	changes to ameliorate patient safety vulnerabilities.	[None]	changes to ameliorate patient safety v
•1.A.1.a).(2)	Residents, fellows, faculty members, and other clinical staff members		changes to amenorate patient safety v
VI.A.1.a).(2).(a)	must:	[None]	
			Residents, fellows, faculty members, a
	know their responsibilities in reporting patient safety events and unsafe		must know their responsibilities in rep
	conditions at the clinical site, including how to report such events; and,		unsafe conditions at the clinical site, i
VI.A.1.a).(2).(a).(i)	(Core)	6.2.	(Core)
			Residents, fellows, faculty members, a
	be provided with summary information of their institution's patient safety		must be provided with summary inform
VI.A.1.a).(2).(a).(ii)	reports. (Core)	6.2.a.	safety reports. ^(Core)
	Residents must participate as team members in real and/or simulated		Residents must participate as team m
	interprofessional clinical patient safety and quality improvement activities,		interprofessional clinical patient safet
	such as root cause analyses or other activities that include analysis, as		such as root cause analyses or other
VI.A.1.a).(2).(b)	well as formulation and implementation of actions. (Core)	6.3.	well as formulation and implementation
	Quality Metrics		
			Quality Metrics
	Access to data is essential to prioritizing activities for care improvement	[Nono]	Access to data is essential to prioritiz
VI.A.1.a).(3)	and evaluating success of improvement efforts.	[None]	and evaluating success of improveme
V = A + (3) (3) (3)	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 po
VI.A.1.a).(3).(a)		J	peneninary related to their patient po

ous identification of vulnerabilities leal with them. An effective is to assess the knowledge, skills, and fety in order to identify areas for

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

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

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

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

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

izing activities for care improvement nent efforts.

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

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Requirement Number	Poquiromont Languago	Requirement Number	Boguiromont
Number	Requirement Language	Number	Requirement
			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 structure
			accountability as it relates to the supe
			Supervision in the setting of graduate
			and effective care to patients; ensures
			skills, knowledge, and attitudes requi
VI.A.2.	Supervision and Accountability	[None]	practice of medicine; and establishes professional growth.
VI.A.2.			
			Supervision and Accountability
	Although the attending physician is ultimately responsible for the care of		Although the attending physician is u
	the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective		the patient, every physician shares in accountability for their efforts in the p
	programs, in partnership with their Sponsoring Institutions, define, widely		programs, in partnership with their Sp
	communicate, and monitor a structured chain of responsibility and		communicate, and monitor a structure
	accountability as it relates to the supervision of all patient care.		accountability as it relates to the supe
	Supervision in the setting of graduate medical education provides safe		Supervision in the setting of graduate
	and effective care to patients; ensures each resident's development of the		and effective care to patients; ensures
	skills, knowledge, and attitudes required to enter the unsupervised		skills, knowledge, and attitudes requi
	practice of medicine; and establishes a foundation for continued	[Nono]	practice of medicine; and establishes
VI.A.2.a)	professional growth.	[None]	professional growth. Residents and faculty members must
	Residents and faculty members must inform each patient of their		respective roles in that patient's care
	respective roles in that patient's care when providing direct patient care.		This information must be available to
VI.A.2.a).(1)	(Core)	6.5.	members of the health care team, and
			Residents and faculty members must respective roles in that patient's care
	This information must be available to residents, faculty members, other		This information must be available to
VI.A.2.a).(1).(a)		6.5.	members of the health care team, and
	The program must demonstrate that the appropriate level of supervision in		The program must demonstrate that the
	place for all residents is based on each resident's level of training and		place for all residents is based on eac
	ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.		ability, as well as patient complexity a exercised through a variety of method
VI.A.2.a).(2)	· · · ·	6.6.	(Core)
	Levels of Supervision		
	To promote appropriate resident supervision while providing for graded		Levels of Supervision To promote appropriate resident supe
	authority and responsibility, the program must use the following		authority and responsibility, the progr
VI.A.2.b)		[None]	classification of supervision.

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

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

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

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

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)

the appropriate level of supervision in ach resident's level of training and and acuity. Supervision may be ods, as appropriate to the situation.

pervision while providing for graded gram must use the following

Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requirement
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 path the resident and the supervising physic patient care through appropriate telec
			Direct Supervision The supervising physician is physical the key portions of the patient interac
VI.A.2.b).(1).(a)	the supervising physician is physically present with the resident during the key portions of the patient interaction.	6.7.	The supervising physician and/or pati the resident and the supervising physic patient care through appropriate telec
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 super the above definition. (Core)
VI.A.2.b).(1).(a).(i).(a)	Each program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. (Core)	6.7.a.1.	Each program must define those physician must be supervised directly until they have defined by the program director, and must demonstrations of competence. (Core)
VI.A.2.b).(1).(a).(i).(b)	Each program must define those physician tasks for which PGY-1 residents may be supervised indirectly with direct supervision available, and must define "direct supervision" in the context of the individual program. (Core)	6.7.a.2.	Each program must define those physici may be supervised indirectly with direct s "direct supervision" in the context of the
			Direct Supervision The supervising physician is physical 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. (Core)	6.7.	The supervising physician and/or pati the resident and the supervising phys patient care through appropriate telec
VI.A.2.b).(1).(b).(i)	Supervision through telecommunication technology must be limited to residents at the PGY-2 level and above. (Core)	6.7.b.	Supervision through telecommunication the PGY-2 level and above. (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 available procedures/encounters with feedback
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physic 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 prog (Core)
VI.A.2.d).(1)	The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)	6.9.a.	The program director must evaluate e specific criteria, guided by the Milesto

ally present with the resident during action.

atient is not physically present with ysician is concurrently monitoring the ecommunication technology.

ally present with the resident during action.

atient is not physically present with ysician is concurrently monitoring the ecommunication technology.

pervised directly, only as described in

ician tasks for which PGY-1 residents have demonstrated competence as hust maintain records of such

cian tasks for which PGY-1 residents t supervision available, and must define e individual program. (Core)

cally present with the resident during action.

atient is not physically present with ysician is concurrently monitoring the ecommunication technology.

n technology must be limited to residents

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

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

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

each resident's abilities based on tones. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
	Faculty members functioning as supervising physicians must delegate		Faculty members functioning as supe
VI.A.2.d).(2)	portions of care to residents based on the needs of the patient and the skills of each resident. (Core)	6.9.b.	portions of care to residents based or skills of each resident. (Core)
VI.A.2.d).(3)	Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)	6.9.c.	Senior residents or fellows should ser residents in recognition of their progr the needs of each patient and the 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 of circumstances under which the reside conditional independence. (Outcome)
VI.A.2.f)	Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)	6.11.	Faculty supervision assignments must the knowledge and skills of each resid the appropriate level of patient care a
VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with their Sp residents and faculty members conce responsibilities of physicians, includi to be appropriately rested and fit to pr patients. (Core)
VI.B.1.	Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)	6.12.	Professionalism Programs, in partnership with their Sp residents and faculty members conce responsibilities of physicians, includi to be appropriately rested and fit to pr patients. (Core)
VI.B.2.	The learning objectives of the program must:	[None]	
VI.B.2.a)	be accomplished without excessive reliance on residents to fulfill non- physician obligations; (Core)	6.12.a.	The learning objectives of the programe excessive reliance on residents to full
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the program care responsibilities. (Core)
VI.B.2.c)	include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)	6.12.c.	The learning objectives of the program the meaning that each resident finds in physician, including protecting time we administrative support, promoting pro- flexibility, and enhancing professional
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 v provide a culture of professionalism t personal responsibility. (Core)
	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.	6 12 0	Residents and faculty members must their personal role in the safety and w care, including the ability to report un
VI.B.4.	(Core)	6.12.e.	(Core)

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

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

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

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

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

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

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

am must be accomplished without ulfill non-physician obligations. ^(Core)

am must ensure manageable patient

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

o with the Sponsoring Institution, must that supports patient safety and

st demonstrate an understanding of welfare of patients entrusted to their insafe conditions and safety events.

Roman Numeral Requirement		Reformatted Requirement	
Number	Requirement Language	Number	Requiremen
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)
	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		Programs, in partnership with their S process for education of residents ar behavior and a confidential process f
VI.B.6.	addressing such concerns. (Core)	6.12.g.	addressing such concerns. (Core)
	Well-Being		
	Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.		Well-Being Psychological, emotional, and physic development of the competent, caring proactive attention to life inside and o requires that physicians retain the joy own real-life stresses. Self-care and r members of the health care team are professionalism; they are also skills a nurtured in the context of other aspec
VI.C.	Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.	[None]	Residents and faculty members are a Programs, in partnership with their S same responsibility to address well-b competence. Physicians and all mem responsibility for the well-being of ea clinical learning environment models prepares residents with the skills and throughout their careers.
VI.O.	The responsibility of the program, in partnership with the Sponsoring		The responsibility of the program, in
VI.C.1.	Institution, must include:	6.13.	Institution, must include:
VI.C.1.a)	attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)	6.13.a.	attention to scheduling, work intensit impacts resident well-being; (Core)
VI.C.1.b)	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)	6.13.b.	evaluating workplace safety data and and faculty members; (Core)
VI.C.1.c)	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)	6.13.c.	policies and programs that encourag member well-being; and, (Core)
	Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their		Residents must be given the opportu and dental care appointments, includ
VI.C.1.c).(1)	working hours. (Core)	6.13.c.1.	working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty me
VI.C.1.d).(1)	identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)	6.13.d.1.	identification of the symptoms of bur disorders, suicidal ideation, or poten assist those who experience these co
VI.C.1.d).(2)	recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)	6.13.d.2.	recognition of these symptoms in the 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-se

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

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

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

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

n partnership with the Sponsoring

sity, and work compression that

nd addressing the safety of residents

age optimal resident and faculty

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

members in:

urnout, depression, and substance use ential for violence, including means to conditions; (Core) hemselves and how to seek

-screening. (Core)

	complementary skills and attributes (physicians, nurses, and other staff members). Success requires both an unwavering mutual respect for those skills		complementary skills and attributes (phy members). Success requires both an un
VI.E.2.	Effective surgical practices entail the involvement of members with a mix of	6.18.	Teamwork Residents must care for patients in an communication and promotes safe, in the specialty and larger health system Effective surgical practices entail the inv
VI.E.1.c)	č	6.17.c.	each resident's level of education, exper
VI.E.1.b)	During the residency education process, surgical teams should be made up of attending surgeons, residents at various PGY levels, medical students (when appropriate), and other health care providers. (Detail) The work of the caregiver team should be assigned to team members based on	6.17.b.	During the residency education process, attending surgeons, residents at various appropriate), and other health care provi The work of the caregiver team should b
VI.E.1.a)		6.17.a.	The workload associated with optimal cli continuum from the moment of admission
VI.E.1.	Clinical Responsibilities The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient		Clinical Responsibilities The clinical responsibilities for each r patient safety, resident ability, severit illness/condition, and available suppo
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
VI.D.2.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who	6.16.	The program, in partnership with its S adequate sleep facilities and safe tran may be too fatigued to safely return h
VI.D.1.	Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)	6.15.	Fatigue Mitigation Programs must educate all residents of the signs of fatigue and sleep depri fatigue mitigation processes. (Detail)
VI.D.	Fatigue Mitigation	6.15.	Fatigue Mitigation Programs must educate all residents of the signs of fatigue and sleep depri fatigue mitigation processes. (Detail)
VI.C.2.b)	These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical	6.14.b.	These policies must be implemented v consequences for the resident who is work. (Core)
VI.C.2.a)	The program must have policies and procedures in place to ensure	6.14.a.	The program must have policies and program of patient care and ensure c
VI.C.2.	There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)		There are circumstances in which res including but not limited to fatigue, ill medical, parental, or caregiver leave. appropriate length of absence for resi care responsibilities. (Core)
VI.C.1.e)	providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care	6.13.e.	providing access to confidential, affor counseling, and treatment, including 24 hours a day, seven days a week. (C
Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement

ordable mental health assessment, g access to urgent and emergent care (Core)

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

d procedures in place to ensure continuity of patient care. (Core) d without fear of negative is or was unable to provide the clinical

s and faculty members in recognition privation, alertness management, and l)

s and faculty members in recognition privation, alertness management, and

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

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

clinical care of surgical patients is a ion to the point of discharge. (Detail)

es, surgical teams should be made up of us PGY levels, medical students (when oviders. (Detail)

be assigned to team members based on erience, and competence. (Detail)

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

nvolvement of members with a mix of nysicians, nurses, and other staff nwavering mutual respect for those skills itment to the process of patient care.

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
VI.E.2.b)	Residents must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Core)	6.18.b.	Residents must collaborate with fellow s faculty members, other physicians outsid health care providers, to best formulate diverse patient population. (Core)
VI.E.2.c)	Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. (Core)	6.18.c.	Residents must assume personal responsion they are assigned (or which they volunta tasks must be completed in the hours as residents must learn and utilize the estal remaining tasks to another member of the not compromised. (Core)
VI.E.2.d)	Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Core)	6.18.d.	Lines of authority should be defined by p working knowledge of these expected re quality care and patient safety. (Core)
VI.E.3.	Transitions of Care	6.19.	Transitions of Care Programs must design clinical assign patient care, including their safety, fre
VI.E.3.a)	Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)	6.19.	Transitions of Care Programs must design clinical assign patient care, including their safety, fre
VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)	6.19.a.	Programs, in partnership with their Sp and monitor effective, structured han continuity of care and patient safety.
VI.E.3.c)	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)	6.19.b.	Programs must ensure that residents with team members in the hand-off pr
VI.F.	Clinical Experience and Education Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.	[None]	Clinical Experience and Education Programs, in partnership with their S an effective program structure that is educational and clinical experience of opportunities for rest and personal ad
	Maximum Hours of Clinical and Educational Work per Week Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in- house clinical and educational activities, clinical work done from home,	6.20	Maximum Hours of Clinical and Educa Clinical and educational work hours r hours per week, averaged over a four house clinical and educational activit
VI.F.1.	and all moonlighting. (Core)	6.20.	and all moonlighting. (Core) Mandatory Time Free of Clinical Work Residents should have eight hours of
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	and education periods. (Detail)
VI.F.2.a)	Residents should have eight hours off between scheduled clinical work and education periods. (Detail)	6.21.	Mandatory Time Free of Clinical Work Residents should have eight hours of and education periods. (Detail)
VI.F.2.b)	Residents must have at least 14 hours free of clinical work and educationafter 24 hours of in-house call. (Core)Residents must be scheduled for a minimum of one day in seven free of	6.21.a.	Residents must have at least 14 hours after 24 hours of in-house call. (Core) Residents must be scheduled for a m
VI.F.2.c)	clinical work and required education (when averaged over four weeks). At- home call cannot be assigned on these free days. (Core)	6.21.b.	clinical work and required education (home call cannot be assigned on these

surgical residents, and especially with side of their specialty, and non-traditional e treatment plans for an increasingly

onsibility to complete all tasks to which tarily assume) in a timely fashion. These assigned, or, if that is not possible, tablished methods for handing off the resident team so that patient care is

reporting relationships to maximize

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

gnments to optimize transitions in frequency, and structure. (Core) Sponsoring Institutions, must ensure

ind-off processes to facilitate both (Core)

ts are competent in communicating process. (Outcome)

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

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

rk and Education off between scheduled clinical work

rk and Education off between scheduled clinical work

urs free of clinical work and education e)

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

Roman Numeral Requirement		Reformatted Requirement	
Number	Requirement Language	Number	Requirement
			Maximum Clinical Work and Education
	Maximum Clinical Work and Education Davied Length	c 22	Clinical and educational work periods
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	hours of continuous scheduled clinica
	Clinical and educational work periods for residents must not exceed 24		Maximum Clinical Work and Education Clinical and educational work periods
VI.F.3.a)	hours of continuous scheduled clinical assignments. (Core)	6.22.	hours of continuous scheduled clinica
	Up to four hours of additional time may be used for activities related to		Up to four hours of additional time ma
	patient safety, such as providing effective transitions of care, and/or		patient safety, such as providing effect
	resident education. Additional patient care responsibilities must not be		resident education. Additional patient
VI.F.3.a).(1)	assigned to a resident during this time. (Core)	6.22.a.	assigned to a resident during this time
			Clinical and Educational Work Hour E
			In rare circumstances, after handing o
			resident, on their own initiative, may e
			clinical site in the following circumsta
			a single severely ill or unstable patien
VI.F.4.	Clinical and Educational Work Hour Exponitions	6.22	needs of a patient or patient's family;
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	events. (Detail)
			Clinical and Educational Work Hour E
	In rare circumstances, after handing off all other responsibilities, a		In rare circumstances, after handing c resident, on their own initiative, may e
	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		clinical site in the following circumsta
	a single severely ill or unstable patient; to give humanistic attention to the		a single severely ill or unstable patien
	needs of a patient or patient's family; or to attend unique educational		needs of a patient or patient's family;
VI.F.4.a)	events. (Detail)	6.23.	events. (Detail)
	These additional hours of care or education must be counted toward the		These additional hours of care or edu
VI.F.4.b)	80-hour weekly limit. (Detail)	6.23.a.	80-hour weekly limit. (Detail)
1	A Review Committee may grant rotation-specific exceptions for up to 10		A Review Committee may grant rotation
	percent or a maximum of 88 clinical and educational work hours to		percent or a maximum of 88 clinical a
	individual programs based on a sound educational rationale.		individual programs based on a sound
	The Review Committee for Otolaryngology – Head and Neck Surgery will not		The Review Committee for Otolaryngolog
	consider requests for exceptions to the 80-hour limit to the residents' work		consider requests for exceptions to the 8
VI.F.4.c)	week.	6.24.	week.
			Moonlighting
l			Moonlighting must not interfere with t
l			the goals and objectives of the educat
			interfere with the resident's fitness for
VI.F.5.	Moonlighting	6.25.	safety. (Core)
			Moonlighting
	Moonlighting must not interfere with the ability of the resident to achieve		Moonlighting must not interfere with t
	the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient		the goals and objectives of the education interfere with the resident's fitness for
VI.F.5.a)	safety. (Core)	6.25.	safety. (Core)
	Time spent by residents in internal and external moonlighting (as defined		Time spent by residents in internal an
	in the ACGME Glossary of Terms) must be counted toward the 80-hour		in the ACGME Glossary of Terms) mus
VI.F.5.b)	maximum weekly limit. (Core)	6.25.a.	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 r

ent Language
tion Period Length
ods for residents must not exceed 24
nical assignments. (Core)
tion Period Length
ods for residents must not exceed 24
nical assignments. (Core)
may be used for activities related to fective transitions of care, and/or
ent care responsibilities must not be
ime. (Core)
r Exceptions
g off all other responsibilities, a
y elect to remain or return to the
stances: to continue to provide care to
ient; to give humanistic attention to the
ly; or to attend unique educational
r Exceptions
g off all other responsibilities, a
y elect to remain or return to the
stances: to continue to provide care to ient; to give humanistic attention to the
ly; or to attend unique educational
ly, or to attend unique educational
ducation must be counted toward the
ation-specific exceptions for up to 10
ation-specific exceptions for up to 10 I and educational work hours to
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ation-specific exceptions for up to 10 I and educational work hours to
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ation-specific exceptions for up to 10 I and educational work hours to und educational rationale. plogy – Head and Neck Surgery will not
ation-specific exceptions for up to 10 I and educational work hours to und educational rationale. blogy – Head and Neck Surgery will not e 80-hour limit to the residents' work
ation-specific exceptions for up to 10 I and educational work hours to und educational rationale. blogy – Head and Neck Surgery will not e 80-hour limit to the residents' work
ation-specific exceptions for up to 10 I and educational work hours to und educational rationale. blogy – Head and Neck Surgery will not e 80-hour limit to the residents' work
ation-specific exceptions for up to 10 I and educational work hours to und educational rationale. blogy – Head and Neck Surgery will not e 80-hour limit to the residents' work
ation-specific exceptions for up to 10 I and educational work hours to und educational rationale. blogy – Head and Neck Surgery will not e 80-hour limit to the residents' work
ation-specific exceptions for up to 10 I and educational work hours to und educational rationale. blogy – Head and Neck Surgery will not e 80-hour limit to the residents' work
ation-specific exceptions for up to 10 I and educational work hours to und educational rationale. ology – Head and Neck Surgery will not e 80-hour limit to the residents' work th the ability of the resident to achieve cational program, and must not for work nor compromise patient

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

o moonlight. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
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)	Night float rotations cannot exceed two consecutive months in duration, and residents can have no more than three months of night float assignments per year. (Core)	6.26.a.	Night float rotations cannot exceed two residents can have no more than three ryear. (Core)
VI.F.6.b)	There must be at least two months between each night float rotation. (Core)	6.26.b.	There must be at least two months betw
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 Frequenc 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)	6.28.	At-Home Call Time spent on patient care activities I 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 res

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

o consecutive months in duration, and e months of night float assignments per

tween each night float rotation. (Core)

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

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