Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requiremen
	Definition of Graduate Medical Education		
			Definition of Graduate Medical Educa
	Fellowship is advanced graduate medical education beyond a core		Fellowship is advanced graduate med
	residency program for physicians who desire to enter more specialized		residency program for physicians wh
	practice. Fellowship-trained physicians serve the public by providing		practice. Fellowship-trained physicial
	subspecialty care, which may also include core medical care, acting as a		subspecialty care, which may also inc
	community resource for expertise in their field, creating and integrating		community resource for expertise in t
	new knowledge into practice, and educating future generations of		new knowledge into practice, and edu
	physicians. Graduate medical education values the strength that a diverse		physicians. Graduate medical educate
	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
	<i>Fellows who have completed residency are able to practice autonomously</i>		Fellows who have completed residen
	in their core specialty. The prior medical experience and expertise of		in their core specialty. The prior medi
	fellows distinguish them from physicians entering residency. The fellow's		fellows distinguish them from physic
	care of patients within the subspecialty is undertaken with appropriate		care of patients within the subspecial
	faculty supervision and conditional independence. Faculty members		faculty supervision and conditional in
	serve as role models of excellence, compassion, cultural sensitivity,		serve as role models of excellence, co
	professionalism, and scholarship. The fellow develops deep medical		professionalism, and scholarship. The
	knowledge, patient care skills, and expertise applicable to their focused		knowledge, patient care skills, and ex
	area of practice. Fellowship is an intensive program of subspecialty		area of practice. Fellowship is an inte
	clinical and didactic education that focuses on the multidisciplinary care		clinical and didactic education that fo
	of patients. Fellowship education is often physically, emotionally, and		of patients. Fellowship education is o
	intellectually demanding, and occurs in a variety of clinical learning		intellectually demanding, and occurs
	environments committed to graduate medical education and the well-		environments committed to graduate
1	being of patients, residents, fellows, faculty members, students, and all	[News]	being of patients, residents, fellows, f
Int.A.	members of the health care team.	[None]	members of the health care team.
	In addition to clinical education, many fellowship programs advance		In addition to clinical education, many
	fellows' skills as physician-scientists. While the ability to create new		fellows' skills as physician-scientists
	knowledge within medicine is not exclusive to fellowship-educated		knowledge within medicine is not exc
	physicians, the fellowship experience expands a physician's abilities to		physicians, the fellowship experience
	pursue hypothesis-driven scientific inquiry that results in contributions to		pursue hypothesis-driven scientific ir
	the medical literature and patient care. Beyond the clinical subspecialty		the medical literature and patient care
	expertise achieved, fellows develop mentored relationships built on an		expertise achieved, fellows develop n
Int.A (Continued)	infrastructure that promotes collaborative research.	[None] - (Continued)	infrastructure that promotes collabor
	Definition of Subspecialty		Definition of Subspecialty
			Pulmonary medicine focuses on the etio
	Pulmonary medicine focuses on the etiology, diagnosis, prevention, and		treatment of diseases affecting the respi
	treatment of diseases affecting the respiratory system. Critical care medicine is		concerned with the diagnosis, managem
	concerned with the diagnosis, management, and prevention of complications in		patients who are severely ill and who us
	patients who are severely ill and who usually require intensive monitoring and/or		and/or organ system support. Pulmonary
	organ system support. Pulmonary disease and critical care medicine fellowships		fellowships provide advanced education
	provide advanced education to allow fellows to acquire competence in these		in these subspecialties with sufficient ex
Int.B.	subspecialties with sufficient expertise to act as an independent consultant.	[None]	consultant.

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edical education beyond a core who desire to enter more specialized ians serve the public by providing include core medical care, acting as a in their field, creating and integrating ducating future generations of ation values the strength that a diverse cal care, and the importance of learning environments.

ency are able to practice autonomously dical experience and expertise of icians entering residency. The fellow's falty is undertaken with appropriate independence. Faculty members compassion, cultural sensitivity, The fellow develops deep medical expertise applicable to their focused tensive program of subspecialty focuses on the multidisciplinary care often physically, emotionally, and rs in a variety of clinical learning te medical education and the well-, faculty members, students, and all

ny fellowship programs advance ts. While the ability to create new eclusive to fellowship-educated ce expands a physician's abilities to inquiry that results in contributions to pre. Beyond the clinical subspecialty mentored relationships built on an orative research.

iology, diagnosis, prevention, and piratory system. Critical care medicine is ement, and prevention of complications in usually require intensive monitoring ary disease and critical care medicine on to allow fellows to acquire competence expertise to act as an independent

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
	Length of Educational Program		Length of Educational Program
Int.C.	The educational program in pulmonary disease and critical care medicine must be 36 months in length. (Core)	4.1.	The educational program in pulmonary d be 36 months in length. (Core)
l.	Oversight	Section 1	Section 1: Oversight
	Sponsoring Institution The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements.		Sponsoring Institution The Sponsoring Institution is the orga ultimate financial and academic respo medical education consistent with the
I.A.	When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.	[None]	When the Sponsoring Institution is no most commonly utilized site of clinica 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)
I.B.	Participating Sites A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.	[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)
I.B.1.a)	A pulmonary disease and critical care medicine fellowship must function as an integral part of an ACGME-accredited program in internal medicine. (Core)	1.2.a.	A pulmonary disease and critical care me integral part of an ACGME-accredited pr
I.B.1.b)	There must be a collaborative relationship with the program director of the internal medicine residency program to ensure compliance with the ACGME accreditation requirements. (Core)	1.2.b.	There must be a collaborative relationshi internal medicine residency program to e accreditation requirements. (Core)
I.B.2.	There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)	1.3.	There must be a program letter of agro and each participating site that govern program and the participating site pro
I.B.2.a)	The PLA must:	[None]	
I.B.2.a).(1) I.B.2.a).(2)	be renewed at least every 10 years; and, (Core) be approved by the designated institutional official (DIO). (Core)	1.3.a. 1.3.b.	The PLA must be renewed at least ever 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, who is accountable for fellow education for that site, in collaboration with the program director. (Core)	1.5.	At each participating site there must by by the program director, who is accou site, in collaboration with the program
I.B.4.	The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)		The program director must submit any participating sites routinely providing for all fellows, of one month full time of ACGME's Accreditation Data System
I.B.5.	The program should ensure that fellows are not unduly burdened by required rotations at geographically distant sites. (Core)	1.6.a.	The program should ensure that fellows rotations at geographically distant sites.

disease and critical care medicine must

ganization or entity that assumes the consibility for a program of graduate he ACGME Institutional Requirements.

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 fellows.

consoring Institution, must designate a

medicine fellowship must function as an program in internal medicine. (Core)

ship with the program director of the onsure compliance with the ACGME

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 ountable for fellow education for that im director. (Core)

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

s are not unduly burdened by required s. (Core)

Roman Numeral	De multimente de la munera	Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requirement
	Workforce Recruitment and Retention		
			Workforce Recruitment and Retention
	The program, in partnership with its Sponsoring Institution, must engage		The program, in partnership with its S
	in practices that focus on mission-driven, ongoing, systematic recruitment		in practices that focus on mission-dri
	and retention of a diverse and inclusive workforce of residents (if present),		and retention of a diverse and inclusi
	fellows, faculty members, senior administrative GME staff members, and		fellows, faculty members, senior adm
I.C.	other relevant members of its academic community. (Core)	1.7.	other relevant members of its academ
			Resources
			The program, in partnership with its S
I.D.	Resources	1.8.	the availability of adequate resources
			Resources
	The program, in partnership with its Sponsoring Institution, must ensure	4.0	The program, in partnership with its S
I.D.1.	the availability of adequate resources for fellow education. (Core)	1.8.	the availability of adequate resources
I.D.1.a)	The program, in partnership with its Sponsoring Institution, must:	[None]	
	ansure the program has adequate energy evallable, including meeting reams		The program, in partnership with its Spo
	ensure the program has adequate space available, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids,		program has adequate space available, examination rooms, computers, visual ar
I.D.1.a).(1)	and office space; (Core)	1.8.a.	space. (Core)
			The program, in partnership with its Spo
	ensure that appropriate in-person or remote/virtual consultations, including		appropriate in-person or remote/virtual c
	those done using telecommunication technology, are available in settings in		using telecommunication technology, are
I.D.1.a).(2)	which fellows work; (Core)	1.8.b.	work. (Core)
			The program, in partnership with its Spo
I.D.1.a).(3)	provide access to an electronic health record (EHR); and, (Core)	1.8.c.	to an electronic health record (EHR). (Co
			The program, in partnership with its Spo
	provide fellows with access to training using simulation to support fellow		with access to training using simulation t
I.D.1.a).(4)	education and patient safety. (Core)	1.8.d.	safety.
I.D.1.b)		[None]	<u> </u>
	timely bedside imaging services, including portable chest x-ray (CXR), bedside		Timely bedside imaging services, includi
	ultrasound, and echocardiogram for patients in the critical care units; and,	1.8.e.	ultrasound, and echocardiogram for pati available at the primary clinical site. (Co
I.D.1.b).(1)	(Core)	1.0.e.	Computed tomography (CT) imaging, inc
I.D.1.b).(2)	computed tomography (CT) imaging, including CT angiography. (Core)	1.8.f.	available at the primary clinical site. (Co
I.D.1.c)		[None]	
/			A bronchoscopy suite, including appropr
	a bronchoscopy suite, including appropriate space, time allocation, and staffing		for pulmonary procedures must be available
I.D.1.c).(1)	for pulmonary procedures; (Core)	1.8.g.	participating sites. (Core)
			A pulmonary function testing laboratory r
I.D.1.c).(2)	a pulmonary function testing laboratory; and, (Core)	1.8.h.	site or participating sites. (Core)
			A supporting laboratory that provides con
	a supporting laboratory that provides complete and prompt laboratory evaluation		evaluation that allows for reliable and tin
I.D.1.c).(3)	that allows for reliable and timely return of laboratory test results. (Core)	1.8.i.	must be available at the primary clinical
I.D.1.c).(4)	The following support services must be available:	1.8.j.	The following support services must be a
I.D.1.c).(4).(a)	an active open heart surgery program; (Core)	1.8.j.1.	an active open heart surgery program; (
I.D.1.c).(4).(b)	a diagnostic laboratory for sleep disorders; (Core)	1.8.j.2.	a diagnostic laboratory for sleep disorde
I.D.1.c).(4).(c)	pathology services, including exfoliative cytology; (Core)	1.8.j.3.	pathology services, including exfoliative

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

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

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

oonsoring Institution, must ensure the e, including meeting rooms, classrooms, and other educational aids, and office

oonsoring Institution, must ensure that consultations, including those done are available in settings in which fellows

onsoring Institution, must provide access Core)

oonsoring Institution, must provide fellows n to support fellow education and patient

iding portable chest x-ray (CXR), bedside atients in the critical care units must be core)

ncluding CT angiography must be Core)

priate space, time allocation, and staffing illable at the primary clinical site or

/ must be available at the primary clinical

complete and prompt laboratory imely return of laboratory test results al site or participating sites. (Core) e available:

(Core)

lers; (Core)

e cytology; (Core)

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I.D.1.c).(4).(d)	a thoracic surgery service;(Core)	1.8.j.4.	a thoracic surgery service;(Core)
I.D.1.c).(4).(e)	an active emergency service; (Core)	1.8.j.5.	an active emergency service; (Core)
I.D.1.c).(4).(f)	postoperative care and respiratory care services; (Core)	1.8.j.6.	postoperative care and respiratory care
I.D.1.c).(4).(g)	nutritional support services; and, (Core)	1.8.j.7.	nutritional support services; and, (Core)
, (, (0)	equipment, expertise and personnel to provide both continuous and intermittent	-	equipment, expertise and personnel to p
I.D.1.c).(4).(h)	renal replacement therapy in the critical care units. (Core)	1.8.j.8.	renal replacement therapy in the critical
I.D.1.c).(5)	Critical care unit(s) must be located in a designated area within the hospital and must be constructed and designed specifically for the care of critically ill patients. (Core)	1.8.k.	Critical care unit(s) must be located in a must be constructed and designed speci patients. (Core)
I.D.1.c).(5).(a)	Whether operating in separate locations or in combined facilities, the program must provide the equivalent of a medical intensive care unit (MICU), a surgical intensive care unit (SICU), and a coronary intensive care unit (CICU). (Detail)	1.8.k.1.	Whether operating in separate locations must provide the equivalent of a medical intensive care unit (SICU), and a coronal
I.D.1.c).(6)	The MICU or its equivalent must be at the primary clinical site, and should be the focus of a teaching service. (Core)	1.8.k.2.	The MICU or its equivalent must be at th the focus of a teaching service. (Core)
I.D.1.c).(6).(a)	There must be an average daily census of at least five patients per fellow during assignments to critical care units. (Detail)	1.8.1.	There must be an average daily census a assignments to critical care units. (Detail
I.D.1.c).(7)	There must be facilities to care for patients with acute myocardial infarction, severe trauma, shock, recent open-heart surgery, recent major thoracic or abdominal surgery, and severe neurologic and neurosurgical conditions. (Core)	1.8.m.	There must be facilities to care for patier severe trauma, shock, recent open-hear abdominal surgery, and severe neurolog
I.D.1.c).(8)	Other services should be available, including anesthesiology, immunology, laboratory medicine, microbiology, occupational medicine, otolaryngology – head and neck surgery, pathology, physical medicine and rehabilitation, and radiology. (Core)	1.8.n.	Other services should be available, inclu laboratory medicine, microbiology, occup head and neck surgery, pathology, physi radiology. (Core)
I.D.1.d)	The program must provide fellows with a patient population representative of both the broad spectrum of clinical disorders and medical conditions managed by subspecialists in this area, and of the community being served by the program. (Core)	1.8.0.	The program must provide fellows with a both the broad spectrum of clinical disord by subspecialists in this area, and of the program. (Core)
I.D.2.	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow well-being and provide for:	1.9.	The program, in partnership with its S healthy and safe learning and working 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 fellows with proximity appropriate for safe patient care; (Core)	1.9.b.	safe, quiet, clean, and private sleep/re for fellows with proximity appropriate
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 lactatio with proximity appropriate for safe pa
I.D.2.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures approp (Core)
I.D.2.e)	accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)	1.9.e.	accommodations for fellows with disa Sponsoring Institution's policy. (Core
I.D.3.	Fellows must have ready access to subspecialty-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.	Fellows must have ready access to su appropriate reference material in print include access to electronic medical I capabilities. (Core)

e services; (Core)

provide both continuous and intermittent al care units. (Core)

a designated area within the hospital and ecifically for the care of critically ill

ns or in combined facilities, the program al intensive care unit (MICU), a surgical ary intensive care unit (CICU). (Detail) the primary clinical site, and should be

is of at least five patients per fellow during ail)

ents with acute myocardial infarction, art surgery, recent major thoracic or ogic and neurosurgical conditions. (Core)

luding anesthesiology, immunology, upational medicine, otolaryngology – vsical medicine and rehabilitation, and

a patient population representative of orders and medical conditions managed ne community being served by the

Sponsoring Institution, must ensure ng environments that promote fellow

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

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

priate to the participating site; and,

sabilities consistent with the re)

subspecialty-specific and other int or electronic format. This must literature databases with full text

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	Other Learners and Health Care Personnel		Other Learners and Health Care Perso
	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		The presence of other learners and of but not limited to residents from othe and advanced practice providers, mu
I.E.	appointed fellows' education. (Core)	1.11.	appointed fellows' education. (Core)
II.	Personnel	Section 2	Section 2: Personnel
II.A.	Program Director	2.1.	Program Director There must be one faculty member an authority and accountability for the or with all applicable program requireme
II.A.1.	There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)	2.1.	Program Director There must be one faculty member an authority and accountability for the ov with all applicable program requireme
II.A.1.a)	The Sponsoring Institution's Graduate Medical Education Committee (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 Graduate (GMEC) must approve a change in pro program director's licensure and clini
II.A.1.a).(1)	Final approval of the program director resides with the Review Committee. (Core)	2.2.a.	Final approval of the program directo (Core)
II.A.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)	2.3.	The program director and, as applical 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
	Number of Approved Fellow Positions: <7 Minimum Support Required (FTE): 0.20		Number of Approved Fellow Positions: < 0.20
	Number of Approved Fellow Positions: 7-9 Minimum Support Required (FTE): 0.25		Number of Approved Fellow Positions: 7 0.25
	Number of Approved Fellow Positions: 10-12 Minimum Support Required (FTE): 0.30		Number of Approved Fellow Positions: 1 (FTE): 0.30
	Number of Approved Fellow Positions: 13-15 Minimum Support Required (FTE): 0.35		Number of Approved Fellow Positions: 1 (FTE): 0.35
	Number of Approved Fellow Positions: 16-18 Minimum Support Required (FTE): 0.40		Number of Approved Fellow Positions: 1 (FTE): 0.40
	Number of Approved Fellow Positions: 19-21 Minimum Support Required (FTE): 0.45		Number of Approved Fellow Positions: 1 (FTE): 0.45
II.A.2.a)	Number of Approved Fellow Positions: >21 Minimum Support Required (FTE): 0.50	2.3.a.	Number of Approved Fellow Positions: > 0.50
II.A.2.b)	Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director(s). (Core)	2.3.b.	Programs must appoint at least one of the members to be associate program direct

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other health care personnel, including her programs, subspecialty fellows, nust not negatively impact the e)
appointed as program director with overall program, including compliance ments. (Core)
appointed as program director with overall program, including compliance ments. (Core)
ate Medical Education Committee program director and must verify the linical appointment. (Core)
ctor resides with the Review Committee.
cable, the program's leadership team, quate for administration of the program ion. (Core)
nust be provided with the dedicated time nistration of the program: (Core)
:: <7 Minimum Support Required (FTE):

- : 7-9 | Minimum Support Required (FTE):
- : 10-12 | Minimum Support Required
- : 13-15 | Minimum Support Required
- : 16-18 | Minimum Support Required
- : 19-21 | Minimum Support Required
- : >21 | Minimum Support Required (FTE):

the subspecialty-certified core faculty ector(s). (Core)

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Requirement Number	Requirement Language	Requirement Number	Requirement Language
	The associate program director(s) must be provided with support equal to a		The associate program director(s) must be provided with support equal to a
	dedicated minimum time for administration of the program as follows: (Core)		dedicated minimum time for administration of the program as follows: (Core)
	Number of Approved Fellow Positions: <7 Minimum Aggregate Support		Number of Approved Fellow Positions: <7 Minimum Aggregate Support
	Required (FTE): Refer to PR II.B.4.d)		Required (FTE): Refer to PR 2.10.d.
	Number of Approved Fellow Positions: 7-9 Minimum Aggregate Support Required (FTE): 0.13		Number of Approved Fellow Positions: 7-9 Minimum Aggregate Support Required (FTE): 0.13
	Number of Approved Fellow Positions: 10-12 Minimum Aggregate Support		Number of Approved Fellow Positions: 10-12 Minimum Aggregate Support
	Required (FTE): 0.14		Required (FTE): 0.14
	Number of Approved Fellow Positions: 13-15 Minimum Aggregate Support Required (FTE): 0.15		Number of Approved Fellow Positions: 13-15 Minimum Aggregate Support Required (FTE): 0.15
	Number of Approved Fellow Positions: 16-18 Minimum Aggregate Support Required (FTE): 0.16		Number of Approved Fellow Positions: 16-18 Minimum Aggregate Support Required (FTE): 0.16
	Number of Approved Fellow Positions: 19-21 Minimum Aggregate Support		Number of Approved Fellow Positions: 19-21 Minimum Aggregate Support
	Required (FTE): 0.17		Required (FTE): 0.17
	Number of Approved Fellow Positions: 22-24 Minimum Aggregate Support		Number of Approved Fellow Positions: 22-24 Minimum Aggregate Support
	Required (FTE): 0.18		Required (FTE): 0.18
	Number of Approved Fellow Positions: 25-27 Minimum Aggregate Support		Number of Approved Fellow Positions: 25-27 Minimum Aggregate Support
	Required (FTE): 0.24 Number of Approved Fellow Positions: 28-30 Minimum Aggregate Support		Required (FTE): 0.24 Number of Approved Fellow Positions: 28-30 Minimum Aggregate Support
	Required (FTE): 0.30		Required (FTE): 0.30
	Number of Approved Fellow Positions: 31-33 Minimum Aggregate Support		Number of Approved Fellow Positions: 31-33 Minimum Aggregate Support
	Required (FTE): 0.36		Required (FTE): 0.36
	Number of Approved Fellow Positions: 34-36 Minimum Aggregate Support		Number of Approved Fellow Positions: 34-36 Minimum Aggregate Support
	Required (FTE): 0.42		Required (FTE): 0.42
II.A.2.c)		2.3.c.	
	Number of Approved Fellow Positions: 37-39 Minimum Aggregate Support		Number of Approved Fellow Positions: 37-39 Minimum Aggregate Support
	Required (FTE): 0.48		Required (FTE): 0.48
	Number of Approved Fellow Positions: 40-42 Minimum Aggregate Support		Number of Approved Fellow Positions: 40-42 Minimum Aggregate Support
	Required (FTE): 0.54		Required (FTE): 0.54
	Number of Approved Fellow Positions: 43-45 Minimum Aggregate Support		Number of Approved Fellow Positions: 43-45 Minimum Aggregate Support
	Required (FTE): 0.60		Required (FTE): 0.60
	Number of Approved Fellow Positions: 46-48 Minimum Aggregate Support		Number of Approved Fellow Positions: 46-48 Minimum Aggregate Support
	Required (FTE): 0.66 Number of Approved Fellow Positions: 49-51 Minimum Aggregate Support		Required (FTE): 0.66 Number of Approved Fellow Positions: 49-51 Minimum Aggregate Support
	Required (FTE): 0.72		Required (FTE): 0.72
	Number of Approved Fellow Positions: 52-54 Minimum Aggregate Support		Number of Approved Fellow Positions: 52-54 Minimum Aggregate Support
	Required (FTE): 0.78	2.3.c (Continued)	Required (FTE): 0.78
			Qualifications of the Program Director
			The program director must possess subspecialty expertise and
II.A.3.	Qualifications of the program director:	2.4.	qualifications acceptable to the Review Committee. (Core)
			Qualifications of the Program Director
	must include subspecialty expertise and qualifications acceptable to the		The program director must possess subspecialty expertise and
II.A.3.a)	Review Committee; and, (Core)	2.4.	qualifications acceptable to the Review Committee. (Core)
	The program director must have at least three years of documented educational		The program director must have at least three years of documented educational
	and/or administrative experience in an ACGME-accredited internal medicine		and/or administrative experience in an ACGME-accredited internal medicine
II.A.3.a).(1)	residency or pulmonary disease or critical care medicine fellowship. (Core)	2.4.b.	residency or pulmonary disease or critical care medicine fellowship. (Core)
II.A.3.a)	must include subspecialty expertise and qualifications acceptable to the Review Committee; and, (Core) The program director must have at least three years of documented educational and/or administrative experience in an ACGME-accredited internal medicine	2.4.	The program director must possess subspecialty expertise ar qualifications acceptable to the Review Committee. (Core) Qualifications of the Program Director The program director must possess subspecialty expertise ar qualifications acceptable to the Review Committee. (Core) The program director must have at least three years of documente and/or administrative experience in an ACGME-accredited internal

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
II.A.3.b)	must include current certification in the subspecialty for which they are the program director by the American Board of Internal Medicine (ABIM) or by the American Osteopathic Board of Internal Medicine (AOBIM), or subspecialty qualifications that are acceptable to the Review Committee. (Core)	2.4.a.	The program director must possess c subspecialty for which they are the pr Board of Internal Medicine (ABIM) or by Internal Medicine (AOBIM), or subspeci acceptable to the Review Committee.
II.A.3.b).(1)	The Review Committee only accepts current ABIM or AOBIM certification in pulmonary disease or critical care medicine. (Core)	2.4.a.1.	The Review Committee only accepts cur pulmonary disease or critical care medic
II.A.3.b).(2)	If the program director has ABIM or AOBIM certification in only one of the subspecialties, a faculty member certified in the other subspecialty by the ABIM or AOBIM must be appointed as an associate program director, be responsible for the educational program in that second area, and assist the program director with the administrative and clinical oversight of the program. (Core)	2.4.a.2.	If the program director has ABIM or AOB subspecialties, a faculty member certified or AOBIM must be appointed as an asso for the educational program in that secon with the administrative and clinical overs
II.A.4.	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow education in the context of patient care. (Core)	2.5.	Program Director Responsibilities The program director must have responsibility for: administration and activity; fellow recruitment and select fellows, and disciplinary action; super 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)	2.5.a.	The program director must be a role n
II.A.4.a).(2)	design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)	2.5.b.	The program director must design and consistent with the needs of the comr Sponsoring Institution, and the mission
II.A.4.a).(3)	administer and maintain a learning environment conducive to educating the fellows in each of the ACGME Competency domains; (Core)	2.5.c.	The program director must administer environment conducive to educating t Competency domains. (Core)
II.A.4.a).(4)	have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)	2.5.d.	The program director must have the a physicians and non-physicians as fac sites, including the designation of cor develop and oversee a process to eva (Core)
II.A.4.a).(5)	have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)	2.5.e.	The program director must have the a supervising interactions and/or learni the standards of the program. (Core)
II.A.4.a).(6)	submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)	2.5.f.	The program director must submit acc required and requested by the DIO, GI
II.A.4.a).(7)	provide a learning and working environment in which fellows have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)	2.5.g.	The program director must provide a which fellows have the opportunity to and provide feedback in a confidentia of intimidation or retaliation. (Core)
II.A.4.a).(8)	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, not to promote, or renew the appointment of a fellow; (Core)	2.5.h.	The program director must ensure the Sponsoring Institution's policies and and due process, including when acti- not to promote, or renew the appointm

current certification in the program director by the American by the American Osteopathic Board of ecialty qualifications that are e. (Core)

urrent ABIM or AOBIM certification in licine. (Core)

DBIM certification in only one of the ied in the other subspecialty by the ABIM sociate program director, be responsible ond area, and assist the program director rsight of the program. (Core)

ponsibility, authority, and ad operations; teaching and scholarly ction, evaluation, and promotion of ervision of fellows; and fellow are. (Core)

model of professionalism. (Core)

nd conduct the program in a fashion nmunity, the mission(s) of the sion(s) of the program. (Core)

er and maintain a learning g the fellows 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 fellows from ning environments that do not meet)

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

a learning and working environment in to raise concerns, report mistreatment, ial manner as appropriate, without fear

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

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	ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)	2.5.i.	The program director must ensure the Sponsoring Institution's policies and discrimination. (Core)
II.A.4.a).(9).(a)	Fellows must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Fellows must not be required to sign restrictive covenant. (Core)
II.A.4.a).(10)	document verification of education for all fellows within 30 days of completion of or departure from the program; (Core)	2.5.j.	The program director must document fellows within 30 days of completion (Core)
II.A.4.a).(11)	provide verification of an individual fellow's education upon the fellow's request, within 30 days; and, (Core)	2.5.k.	The program director must provide ve education upon the fellow's request, v
	Faculty Faculty members are a foundational element of graduate medical education – faculty members teach fellows how to care for patients. Faculty members provide an important bridge allowing fellows to grow and become practice ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population. Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the fellows and		Faculty Faculty members are a foundational e education – faculty members teach fe Faculty members provide an important and become practice ready, ensuring quality of care. They are role models to by demonstrating compassion, comme patient care, professionalism, and a con- Faculty members experience the pride development of future colleagues. The the opportunity to teach and model ex- scholarly approach to patient care, fa graduate medical education system, i and the population. Faculty members ensure that patients from a specialist in the field. They rect the patients, fellows, community, and provide appropriate levels of supervise Faculty members create an effective for professional manner and attending to
II.B.	themselves.	[None]	themselves.
II.B.1.	There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)	2.6.	There must be a sufficient number of instruct and supervise all fellows. (Co
II.B.2	Faculty members must:	[None]	
-	be role models of professionalism; (Core)	2.7.	Faculty Responsibilities Faculty members must be role models
	demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)	2.7.a.	Faculty members must demonstrate of equitable, high-quality, cost-effective,
	demonstrate a strong interest in the education of fellows, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)	2.7.b.	Faculty members must demonstrate a fellows, including devoting sufficient fulfill their supervisory and teaching r
	administer and maintain an educational environment conducive to educating fellows; (Core)	2.7.c.	Faculty members must administer and environment conducive to educating

he program's compliance with the discrete the discrete di

n a non-competition guarantee or

nt verification of education for all not or or departure from the program.

verification of an individual fellow's t, within 30 days. (Core)

I element of graduate medical fellows how to care for patients. ant bridge allowing fellows to grow og that patients receive the highest s 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 nd institution. Faculty members vision to promote patient safety. e learning environment by acting in a to the well-being of the fellows and

of faculty members with competence to Core)

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

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

nd maintain an educational g fellows. (Core)

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Requirement Number		Requirement Number	•
	regularly participate in organized clinical discussions, rounds, journal		Faculty members must regularly partic
II.B.2.e)	clubs, and conferences; and, (Core)	2.7.d.	discussions, rounds, journal clubs, ar
	pursue faculty development designed to enhance their skills at least		Faculty members must pursue faculty
II.B.2.f)	annually. (Core)	2.7.e.	their skills at least annually. (Core)
			Faculty Qualifications
II.B.3.	Faculty Qualifications	2.8.	Faculty members must have appropria hold appropriate institutional appointr
II.D.J.		2.0.	Faculty Qualifications
	Faculty members must have appropriate qualifications in their field and		Faculty members must have appropria
II.B.3.a)	hold appropriate institutional appointments. (Core)	2.8.	hold appropriate institutional appointr
II.B.3.b)	Subspecialty physician faculty members must:	[None]	and the state of t
II.B.3.b).(1)	have current certification in the subspecialty by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or possess qualifications judged acceptable to the Review Committee. (Core)		Subspecialty Physician Faculty Memb Subspecialty physician faculty member the subspecialty by the American Boa American Osteopathic Board of Internation judged acceptable to the Review Com
II.B.3.c)	Any other specialty physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the Review Committee. (Core)	2.9.a.	Any other specialty physician faculty i certification in their specialty by the a Medical Specialties (ABMS) member b Association (AOA) certifying board, or acceptable to the Review Committee.
II.B.3.c).(1)	Faculty members who are ABIM- or AOBIM-certified clinical faculty members in cardiology, gastroenterology, hematology, infectious disease, nephrology, and oncology must participate in the program. (Core)	2.9.b.	Faculty members who are ABIM- or AOB cardiology, gastroenterology, hematology oncology must participate in the program
II.B.3.c).(2)	Faculty members from several related disciplines, including anesthesiology, cardiovascular surgery, emergency medicine, general surgery, obstetrics and gynecology, orthopaedic surgery, neurological surgery, neurology, thoracic surgery, urology, and vascular surgery must be available to participate in the program. (Core)	2.9.c.	Faculty members from several related dis cardiovascular surgery, emergency medi gynecology, orthopaedic surgery, neurolo surgery, urology, and vascular surgery m program. (Core)
II.B.4.	Core Faculty Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. (Core)	2.10.	Core Faculty Core faculty members must have a sig supervision of fellows and must devot effort to fellow education and/or admin component of their activities, teach, ev feedback to fellows. (Core)
	Faculty members must complete the annual ACGME Faculty Survey.		Faculty members must complete the a
II.B.4.a)	(Core)	2.10.a.	(Core)

ticipate in organized clinical and conferences. (Core)

ty development designed to enhance

riate qualifications in their field and ntments. (Core)

riate qualifications in their field and ntments. (Core)

nbers

bers must have current certification in oard of Internal Medicine or the rnal Medicine, or possess qualifications mmittee. (Core)

y members must have current appropriate American Board of board or American Osteopathic or possess qualifications judged e. (Core)

DBIM-certified clinical faculty members in ogy, infectious disease, nephrology, and am. (Core)

disciplines, including anesthesiology, edicine, general surgery, obstetrics and ological surgery, neurology, thoracic must be available to participate in the

significant role in the education and vote a significant portion of their entire ninistration, and must, as a evaluate, and provide formative

e annual ACGME Faculty Survey.

Requirement Number Requirement Language Requirement Number Requirement Language In addition to the program director, programs must have the minimum number of core faculty members who are curified in hematology by the ABM or to the ADBM based on the number of approved factor protocols. In addition to the program director, programs must have the minimum number of core faculty members who are curified in hematology by the ABM or ADBM ADBM based on the number of approved factor protocols. In addition to the program director, programs must have the minimum number of ADBM based on the number of approved factor protocols. In addition to the program director, programs must have the minimum number core faculty. Number of Approved Positions: 1-31 [Minimum Number of ABM or AOBIM Certified Core Faculty. Number of Approved Positions: 1-31 [Minimum Number of ABM or AOBIM Certified Core Faculty. Number of Approved Positions: 1-31 [Minimum Number of ABM or AOBIM Certified Core Faculty. Number of Approved Positions: 1-31 [Minimum Number of ABM or AOBIM Certified Core Faculty. Number of Approved Positions: 1-321 [Minimum Number of ABM or AOBIM Certified Core Faculty. Number of Approved Positions: 1-321 [Minimum Number of ABM or AOBIM Number of Approved Positions: 13-33 [Minimum Number of ABM or AOBIM Number of Approved Positions: 13-321 [Minimum Number of ABM or AOBIM Certified Core Faculty. Number of Approved Positions: 13-31 [Minimum Number of ABM or AOBIM Number of Approved Positions: 2-324 [Minimum Number of ABM or AOBIM Certified Core Faculty. Number of Approved Positions: 2-321 [Minimum Number of ABM or AOBIM Number of Approved Positions: 3-33 [Minimum Number of ABM or AOBIM Certified Core Faculty. <	Roman Numeral	Γ	Reformatted	
In addition bits program director, programs must have the minimum number of core faculty members who are cartified in hematology by the ABIM or NDBM AOBIM based on the number of approved fellow positions, as follows: (Core) Number of Approved Positions: 1-31 Minimum Number of ABIM or AOBIM Certified Core Faculty: 2 Number of Approved Positions: 7-9 Minimum Number of ABIM or AOBIM Certified Core Faculty: 3 Number of Approved Positions: 7-9 Minimum Number of ABIM or AOBIM Certified Core Faculty: 3 Number of Approved Positions: 10-12 Minimum Number of ABIM or AOBIM Certified Core Faculty: 3 Number of Approved Positions: 10-12 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 10-12 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 10-12 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 10-12 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 20-21 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 20-21 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 20-23 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 20-23 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 20-23 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 20-23 Minimum Number of ABIM or AOBIM Certified Core Faculty: 22 210.b. Number of Approved Positions: 30-39 Minimum Number of ABIM or AOBIM Certified Core Faculty: 22 Number of Approved Positions: 30-39 Minimum Number of ABIM or AOBIM Certified Core Faculty: 23 Number of Approved Positions: 30-39 Minimum Number of ABIM or AOBIM Certified Core Faculty: 23 Number of Approved Positions: 30-39 Minimum Number of ABIM or AOBIM Certified Core Faculty: 23 Number of Approved Positions: 30-39 Minimum Number of ABIM or AOBIM Certified Core Faculty: 23 Number of Approved		Requirement Language		Requirement Language
In addition to the program director, programs must have the minimum number of core faculty members who are catfiled in hematology by the ABIM or the AOBIM based on the number of approved fellow positions, as follows: (Core) Number of Approved Positions: 1-3 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: 2 Catfiled Core Faculty: -3 Number of Approved Positions: -4-8 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -2 Number of Approved Positions: -10-12 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -2 Number of Approved Positions: -10-12 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -3 Number of Approved Positions: -10-12 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -3 Number of Approved Positions: -10-12 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -4 Number of Approved Positions: -10-12 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -3 Number of Approved Positions: -10-12 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -4 Number of Approved Positions: -10-12 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -10-12] [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -10-12] [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -10-12] [Minimum Number of ABIM or AOBIM Number of Approved Positions: -10-12] [Minimum Number of ABIM or AOBIM Number of Approved Positions: -10-12] [Minimum Number of ABIM or AOBIM Number of Approved Positions: -10-12] [Minimum Number of ABIM or AOBIM Number of Approved Positions: -20-224] [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -10 Number of Approved Positions: -20-221 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -10 Number of Approved Positions: -20-23] [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -21 Number of Approved Positions: -37-39 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -22 Number of Approved Positions: -37-39 [Minimum Number of ABIM or AOBIM Catfiled Core Faculty: -23 Number of Approved Positions: -37-39 [Minimum Num	•			
Certified Core Faculty: 20 Number of Approved Positions: 34-36 Minimum Number of ABIM or AOBIM II.B.4.b) Certified Core Faculty: 22 2.10.b. Number of Approved Positions: 37-39 Minimum Number of ABIM or AOBIM Certified Core Faculty: 22 Number of Approved Positions: 37-39 Minimum Number of ABIM or AOBIM Certified Core Faculty: 24 Number of Approved Positions: 40-42 Minimum Number of ABIM or AOBIM Number of Approved Positions: 40-42 Minimum Number of ABIM or AOBIM Certified Core Faculty: 26 Number of Approved Positions: 43-45 Minimum Number of ABIM or AOBIM Certified Core Faculty: 26 Number of Approved Positions: 43-45 Minimum Number of ABIM or AOBIM Certified Core Faculty: 28 Number of Approved Positions: 43-45 Minimum Number of ABIM or AOBIM Certified Core Faculty: 28 Number of Approved Positions: 49-51 Minimum Number of ABIM or AOBIM Certified Core Faculty: 30 Number of Approved Positions: 49-51 Minimum Number of ABIM or AOBIM Certified Core Faculty: 30 Number of Approved Positions: 52-54 Minimum Number of ABIM or AOBIM LI.B.4.b) - (Continued) Certified Core Faculty: 34 2.10.b (Continued) Certified Core Faculty: 32 Number of Approved Positions: 52-54 Minimum Number of ABIM or AOBIM Certified Core Faculty: 32 Number of Approved Positions: 52-54 Minimum Number of ABIM or AOBIM II.B.4.b) - (Continued) Certified C		core faculty members who are certified in hematology by the ABIM or the AOBIM based on the number of approved fellow positions, as follows: (Core) Number of Approved Positions: 1-3 Minimum Number of ABIM or AOBIM Certified Core Faculty: 2 Number of Approved Positions: 4-6 Minimum Number of ABIM or AOBIM Certified Core Faculty: 3 Number of Approved Positions: 7-9 Minimum Number of ABIM or AOBIM Certified Core Faculty: 4 Number of Approved Positions: 10-12 Minimum Number of ABIM or AOBIM Certified Core Faculty: 6 Number of Approved Positions: 13-15 Minimum Number of ABIM or AOBIM Certified Core Faculty: 8 Number of Approved Positions: 16-18 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 19-21 Minimum Number of ABIM or AOBIM Certified Core Faculty: 12 Number of Approved Positions: 22-24 Minimum Number of ABIM or AOBIM Certified Core Faculty: 14 Number of Approved Positions: 25-27 Minimum Number of ABIM or AOBIM Certified Core Faculty: 16 Number of Approved Positions: 28-30 Minimum Number of ABIM or AOBIM Certified Core Faculty: 18		Number of Approved Positions: 4-6 Minimum Number of ABIM or AOBIM Certified Core Faculty: 3 Number of Approved Positions: 7-9 Minimum Number of ABIM or AOBIM Certified Core Faculty: 4 Number of Approved Positions: 10-12 Minimum Number of ABIM or AOBIM Certified Core Faculty: 6 Number of Approved Positions: 13-15 Minimum Number of ABIM or AOBIM Certified Core Faculty: 8 Number of Approved Positions: 16-18 Minimum Number of ABIM or AOBIM Certified Core Faculty: 10 Number of Approved Positions: 19-21 Minimum Number of ABIM or AOBIM Certified Core Faculty: 12 Number of Approved Positions: 22-24 Minimum Number of ABIM or AOBIM Certified Core Faculty: 14 Number of Approved Positions: 25-27 Minimum Number of ABIM or AOBIM Certified Core Faculty: 16 Number of Approved Positions: 28-30 Minimum Number of ABIM or AOBIM Certified Core Faculty: 18 Number of Approved Positions: 31-33 Minimum Number of ABIM or AOBIM
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Certified Core Faculty: 24 Certified Core Faculty: 24 Number of Approved Positions: 40-42 Minimum Number of ABIM or AOBIM Certified Core Faculty: 26 Number of Approved Positions: 43-45 Minimum Number of ABIM or AOBIM Certified Core Faculty: 26 Number of Approved Positions: 43-45 Minimum Number of ABIM or AOBIM Certified Core Faculty: 28 Number of Approved Positions: 46-48 Minimum Number of ABIM or AOBIM Certified Core Faculty: 28 Number of Approved Positions: 49-51 Minimum Number of ABIM or AOBIM Certified Core Faculty: 30 Number of Approved Positions: 49-51 Minimum Number of ABIM or AOBIM Certified Core Faculty: 32 Number of Approved Positions: 52-54 Minimum Number of ABIM or AOBIM Certified Core Faculty: 32 Number of Approved Positions: 52-54 Minimum Number of ABIM or AOBIM Certified Core Faculty: 32 Number of Approved Positions: 52-54 Minimum Number of ABIM or AOBIM Certified Core Faculty: 32 Number of Approved Positions: 52-54 Minimum Number of ABIM or AOBIM Certified Core Faculty: 34 0f the program director and the required number of subspecialty-certified core faculty: members, at least 50 percent of the individuals must be ABIM- or AOBIM Of the program director and the required number of subspecialty-certified core faculty: members, at least 50 percent of the individuals must be ABIM- or AOBIM	п.б.4.0)		Z. IU.D.	
faculty members, at least 50 percent of the individuals must be ABIM- or AOBIM-	II.B.4.b) - (Continued)	Certified Core Faculty: 24 Number of Approved Positions: 40-42 Minimum Number of ABIM or AOBIM Certified Core Faculty: 26 Number of Approved Positions: 43-45 Minimum Number of ABIM or AOBIM Certified Core Faculty: 28 Number of Approved Positions: 46-48 Minimum Number of ABIM or AOBIM Certified Core Faculty: 30 Number of Approved Positions: 49-51 Minimum Number of ABIM or AOBIM Certified Core Faculty: 32 Number of Approved Positions: 52-54 Minimum Number of ABIM or AOBIM Certified Core Faculty: 34	2.10.b (Continued)	Number of Approved Positions: 40-42 Minimum Number of ABIM or AOBIM Certified Core Faculty: 26 Number of Approved Positions: 43-45 Minimum Number of ABIM or AOBIM Certified Core Faculty: 28 Number of Approved Positions: 46-48 Minimum Number of ABIM or AOBIM Certified Core Faculty: 30 Number of Approved Positions: 49-51 Minimum Number of ABIM or AOBIM Certified Core Faculty: 32 Number of Approved Positions: 52-54 Minimum Number of ABIM or AOBIM Certified Core Faculty: 34
II.B.4.c) be ABIM- or AOBIM-certified in critical care medicine. (Core) 2.10.c. be ABIM- or AOBIM-certified in critical care medicine. (Core)		faculty members, at least 50 percent of the individuals must be ABIM- or AOBIM certified in pulmonary disease, and at least 50 percent of the individuals must		Of the program director and the required number of subspecialty-certified core faculty members, at least 50 percent of the individuals must be ABIM- or AOBIM certified in pulmonary disease, and at least 50 percent of the individuals must be ABIM- or AOBIM-certified in critical care medicine. (Core)

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Requirement Number			Requiremen
	The required core faculty members must be provided with support equal to an aggregate minimum of 15 percent/FTE for educational and administrative responsibilities that do not involve direct patient care. Support must be provided based on the program size as follows: (Core)		The required core faculty members must aggregate minimum of 15 percent/FTE for responsibilities that do not involve direct based on the program size as follows: (0)
II.B.4.d)	Number of Approved Fellow Positions: 1-3 Minimum Aggregate Support Required (FTE): 0.15 Number of Approved Fellow Positions: 4-6 Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Fellow Positions: 7-9 Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Fellow Positions: 10-12 Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Fellow Positions: 13-15 Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Fellow Positions: 16-18 Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Fellow Positions: 19-21 Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Fellow Positions: 22-24 Minimum Aggregate Support Required (FTE): 0.25 Number of Approved Fellow Positions: 25-27 Minimum Aggregate Support Required (FTE): 0.25 Number of Approved Fellow Positions: 28-30 Minimum Aggregate Support Required (FTE): 0.25 Number of Approved Fellow Positions: 31-33 Minimum Aggregate Support Required (FTE): 0.25 Number of Approved Fellow Positions: 31-33 Minimum Aggregate Support Required (FTE): 0.25 Number of Approved Fellow Positions: 31-33 Minimum Aggregate Support Required (FTE): 0.25 Number of Approved Fellow Positions: 31-33 Minimum Aggregate Support Required (FTE): 0.25 Number of Approved Fellow Positions: 31-33 Minimum Aggregate Support Required (FTE): 0.25 Number of Approved Fellow Positions: 31-33 Minimum Aggregate Support Required (FTE): 0.25	2.10.d.	Number of Approved Fellow Positions: 1 Required (FTE): 0.15 Number of Approved Fellow Positions: 4 Required (FTE): 0.20 Number of Approved Fellow Positions: 7 Required (FTE): 0.20 Number of Approved Fellow Positions: 1 Required (FTE): 0.25 Number of Approved Fellow Positions: 2 Required (FTE): 0.25 Number of Approved Fellow Positions: 2 Required (FTE): 0.25 Number of Approved Fellow Positions: 2 Required (FTE): 0.25 Number of Approved Fellow Positions: 3 Required (FTE): 0.25 Number of Approved Fellow Positions: 3 Required (FTE): 0.25 Number of Approved Fellow Positions: 3 Required (FTE): 0.25
n.b.4.u)		2.10.u.	Program Coordinator
II.C.	Program Coordinator	2.11.	There must be a program coordinator
II.C.1.	There must be a program coordinator. (Core)	2.11.	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)	2.11.a.	The program coordinator must be pro support adequate for administration o and configuration. (Core)

ust be provided with support equal to an E for educational and administrative ct patient care. Support must be provided (Core)

- 1-3 | Minimum Aggregate Support
- : 4-6 | Minimum Aggregate Support
- 7-9 | Minimum Aggregate Support
- : 10-12 | Minimum Aggregate Support
- : 13-15 | Minimum Aggregate Support
- 16-18 | Minimum Aggregate Support
- : 19-21 | Minimum Aggregate Support
- 22-24 | Minimum Aggregate Support
- 25-27 | Minimum Aggregate Support
- 28-30 | Minimum Aggregate Support
- 31-33 | Minimum Aggregate Support
- : 34+ | Minimum Aggregate Support

or. (Core)

or. (Core)

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

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	At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on the program size as follows: (Core)		At a minimum, the program coordinator time and support specified below for adr administrative support must be provided (Core)
	Number of Approved Fellow Positions: 1-3 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0		Number of Approved Fellow Positions: 1 Coordinator Support: 0.30 Additional A Administration of the Program: 0
	Number of Approved Fellow Positions: 4-6 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.20		Number of Approved Fellow Positions: 4 Coordinator Support: 0.30 Additional A Administration of the Program: 0.20
	Number of Approved Fellow Positions: 7-9 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.38		Number of Approved Fellow Positions: 7 Coordinator Support: 0.30 Additional A Administration of the Program: 0.38
	Number of Approved Fellow Positions: 10-12 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.44		Number of Approved Fellow Positions: 1 Coordinator Support: 0.30 Additional A Administration of the Program: 0.44
	Number of Approved Fellow Positions: 13-15 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.50		Number of Approved Fellow Positions: 1 Coordinator Support: 0.30 Additional A Administration of the Program: 0.50
II.C.2.a)	Number of Approved Fellow Positions: 16-18 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.56	2.11.b.	Number of Approved Fellow Positions: 1 Coordinator Support: 0.30 Additional A Administration of the Program: 0.56

or must be provided with the dedicated dministration of the program. Additional ed based on the program size as follows: 1-3 | Minimum FTE Required for Aggregate FTE Required for 4-6 | Minimum FTE Required for Aggregate FTE Required for 7-9 | Minimum FTE Required for Aggregate FTE Required for 4 Aggregate FTE Required for 4 Aggregate FTE Required for 10-12 | Minimum FTE Required for 4 Aggregate FTE Required for 13-15 | Minimum FTE Required for 4 Aggregate FTE Required for

: 16-18 | Minimum FTE Required for Aggregate FTE Required for

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Requirement Number	Requirement Language	Requirement Number	Requirement Language
	Number of Approved Fellow Positions: 19-21 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.62		Number of Approved Fellow Positions: 19-21 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.62
	Number of Approved Fellow Positions: 22-24 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.68		Number of Approved Fellow Positions: 22-24 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.68
	Number of Approved Fellow Positions: 25-27 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.74		Number of Approved Fellow Positions: 25-27 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.74
	Number of Approved Fellow Positions: 28-30 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.80		Number of Approved Fellow Positions: 28-30 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.80
	Number of Approved Fellow Positions: 31-33 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.86		Number of Approved Fellow Positions: 31-33 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.86
	Number of Approved Fellow Positions: 34-36 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.92		Number of Approved Fellow Positions: 34-36 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.92
	Number of Approved Fellow Positions: 34-36 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.98	2.11.b (Continued)	Number of Approved Fellow Positions: 34-36 Minimum FTE Required for Coordinator Support: 0.30 Additional Aggregate FTE Required for Administration of the Program: 0.98
	Other Program Personnel		
II.D.	The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)	2.12.	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)
	Personnel must include nurses and technicians skilled in critical care		Personnel must include nurses and technicians skilled in critical care
II.D.1.	instrumentation, respiratory function, and laboratory medicine. (Detail)	2.12.a.	instrumentation, respiratory function, and laboratory medicine. (Detail)
	Fellow Appointments	Section 3	Section 3: Fellow Appointments
III.A.	Eligibility Criteria	[None]	
	Eligibility Requirements – Fellowship Programs		Eligibility Requirements – Fellowship Programs
	All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency		All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency
III.A.1.	program located in Canada. (Core)	3.2.	program located in Canada. (Core)

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Requirement Number	Requirement Language	Requirement Number	Requirement
	Fellowship programs must receive verification of each entering fellow's level of competence in the required field using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program. (Core)		Fellowship programs must receive ve level of competence in the required fie CanMEDS Milestones evaluations fror
	Prior to appointment in the fellowship, fellows should have completed an internal medicine program that satisfies the requirements in III.A.1. (Core)	3.2.a.1.	Prior to appointment in the fellowship, fel internal medicine program that satisfies t
III.A.1.b).(1)	Fellows who did not complete an internal medicine program that satisfies the requirements in III.A.1. must have completed at least three years of internal medicine education prior to starting the fellowship as well as met all of the criteria in the "Fellow Eligibility Exception" section below. (Core)	3.2.a.1.a.	Fellows who did not complete an internal requirements in 3.2. must have complete medicine education prior to starting the for criteria in the "Fellow Eligibility Exception
	Fellow Eligibility Exception The Review Committee for Internal Medicine will allow the following exception to the fellowship eligibility requirements:	3.2.b.	Fellow Eligibility Exception The Review Committee for Internal Me exception to the fellowship eligibility i
	An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1., but who does meet all of the following additional qualifications and conditions: (Core)	3.2.b.1.	An ACGME-accredited fellowship prog qualified international graduate applic eligibility requirements listed in 3.2, b additional qualifications and condition
	evaluation by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and, (Core)	3.2.b.1.a.	evaluation by the program director an the applicant's suitability to enter the review of the summative evaluations o (Core)
III.A.1.c).(1).(b)	review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)	3.2.b.1.b.	review and approval of the applicant's GMEC; and, (Core)
III.A.1.c).(1).(c)	verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)	3.2.b.1.c.	verification of Educational Commissic (ECFMG) certification. (Core)
	Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)	3.2.b.2.	Applicants accepted through this exce their performance by the Clinical Com of matriculation. (Core)
	Fellow Complement The program director must not appoint more fellows than approved by the Review Committee. (Core)		Fellow Complement The program director must not appoir Review Committee. (Core)
	Fellow Transfers The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring fellow, and Milestones evaluations upon matriculation. (Core)		Fellow Transfers The program must obtain verification and a summative competency-based p acceptance of a transferring fellow, ar matriculation. (Core)

verification of each entering fellow's field using ACGME, ACGME-I, or rom the core residency program. (Core)

fellows should have completed an s the requirements in 3.2. ^(Core)

nal medicine program that satisfies the eted at least three years of internal e fellowship as well as met all of the on" section below. (Core)

ledicine will allow the following y requirements:

rogram may accept an exceptionally licant who does not satisfy the but who does meet all of the following ions: (Core)

and fellowship selection committee of he program, based on prior training and s of training in the core specialty; and,

t's exceptional qualifications by the

sion for Foreign Medical Graduates

cception must have an evaluation of ompetency Committee within 12 weeks

pint more fellows than approved by the

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

Roman Numeral Reguirement Number	Requirement Language	Reformatted Requirement Number	Doguiromant
Requirement Number			Requirement
	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 d and innovation in graduate medical ec organizational affiliation, size, or locat
	The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.		The educational program must suppor knowledgeable, skillful physicians wh
IV.	It is recognized that 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 that programs may pla leadership, public health, etc. It is exp reflect the nuanced program-specific g example, it is expected that a program scientists will have a different curricul community health.
	Educational Components		Educational Components
IV.A.	The curriculum must contain the following educational components:	4.2.	The curriculum must contain the follow
IV.A.1.	a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, fellows, and faculty members; (Core)	4.2.a.	a set of program aims consistent with mission, the needs of the community i capabilities of its graduates, which mu applicants, fellows, and faculty membe
IV.A.2.	competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice in their subspecialty. These must be distributed, reviewed, and available to fellows and faculty members; (Core)	4.2.b.	competency-based goals and objectiv designed to promote progress on a tra their subspecialty. These must be dist fellows and faculty members; (Core)
IV.A.3.	delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty; (Core)	4.2.c.	delineation of fellow responsibilities for responsibility for patient management subspecialty; (Core)
IV.A.4.	structured educational activities beyond direct patient care; and, (Core)	4.2.d.	structured educational activities beyo
IV.A.4.a)	Fellows must be provided with protected time to participate in core didactic activities. (Core)	4.11.	Didactic and Clinical Experiences Fellows must be provided with protect didactic activities. (Core)
IV.A.5.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)	4.2.e.	formal educational activities that pron tools, and techniques. (Core)
			ACGME Competencies The Competencies provide a concepture 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 Competencie Milestones for each subspecialty. The subspecialty-specific patient care and
IV.B.	ACGME Competencies	[None]	refining the other competencies acqui

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

oort the development of who provide compassionate care.

place 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:

th the Sponsoring Institution's y it serves, and the desired distinctive must be made available to program nbers; (Core)

tives for each educational experience trajectory to autonomous practice in istributed, reviewed, and available to

for patient care, progressive ent, and graded supervision in their

yond direct patient care; and, (Core)

ected time to participate in core

omote patient safety-related goals,

otual framework describing the ician to enter autonomous practice. e practice of all physicians, although each subspecialty. The developmental ncies are articulated through the he focus in fellowship is on nd medical knowledge, as well as juired in residency.

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rtoquironioni itunisor	The program must integrate the following ACGME Competencies into the		Kequitement
IV.B.1.	curriculum:	[None]	The program must integrate all ACGM
	Professionalism		
			ACGME Competencies – Professional
	Fellows must demonstrate a commitment to professionalism and an		Fellows must demonstrate a commitm
IV.B.1.a)	adherence to ethical principles. (Core)	4.3.	adherence to ethical principles. (Core
IV.B.1.b)	Patient Care and Procedural Skills	[None]	
IV.B.1.b).(1)	Fellows must be able to provide patient care that is patient- and family- centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)	4.4.	ACGME Competencies – Patient Care Fellows must be able to provide patie centered, compassionate, equitable, a treatment of health problems and the
	Fellows must demonstrate competence in the evaluation, and management of		Fellows must demonstrate competence i
IV.B.1.b).(1).(a)	inpatients and outpatients with:	4.4.a.	inpatients and outpatients with:
IV.B.1.b).(1).(a).(i)	acute lung injury, including radiation, inhalation, and trauma; (Core)	4.4.a.1.	acute lung injury, including radiation, inh
	acute metabolic disturbances, including overdosages and intoxication		acute metabolic disturbances, including
IV.B.1.b).(1).(a).(ii)	syndromes; (Core)	4.4.a.2.	syndromes; (Core)
IV.B.1.b).(1).(a).(iii)	anaphylaxis and acute allergic reactions in the critical care unit; (Core)	4.4.a.3.	anaphylaxis and acute allergic reactions
IV.B.1.b).(1).(a).(iv)	cardiovascular diseases in the critical care unit; (Core)	4.4.a.4.	cardiovascular diseases in the critical ca
IV.B.1.b).(1).(a).(v)	circulatory failure; (Core)	4.4.a.5.	circulatory failure; (Core)
IV.B.1.b).(1).(a).(vi)	detection and prevention of iatrogenic and nosocomial problems in critical care medicine; (Core)	4.4.a.6.	detection and prevention of iatrogenic ar medicine; (Core)
IV.B.1.b).(1).(a).(vii)	diffuse interstitial lung disease; (Core)	4.4.a.7.	diffuse interstitial lung disease; (Core)
IV.B.1.b).(1).(a).(viii)	disorders of the pleura and the mediastinum; (Core)	4.4.a.8.	disorders of the pleura and the mediastir
IV.B.1.b).(1).(a).(ix)	end-of-life issues and palliative care; (Core)	4.4.a.9.	end-of-life issues and palliative care; (Co
IV.B.1.b).(1).(a).(x)	hypertensive emergencies; (Core)	4.4.a.10.	hypertensive emergencies; (Core)
IV.B.1.b).(1).(a).(xi)	iatrogenic respiratory diseases, including drug-induced disease; (Core)	4.4.a.11.	iatrogenic respiratory diseases, including
IV.B.1.b).(1).(a).(xii)	immunosuppressed conditions in the critical care unit; (Core)	4.4.a.12.	immunosuppressed conditions in the crit
	metabolic, nutritional, and endocrine effects of critical illness, and hematologic		metabolic, nutritional, and endocrine effe
IV.B.1.b).(1).(a).(xiii)	and coagulation disorders associated with critical illness; (Core)	4.4.a.13.	and coagulation disorders associated wit
IV.B.1.b).(1).(a).(xiv)	multi-organ system failure; (Core)	4.4.a.14.	multi-organ system failure; (Core)
	obstructive lung diseases, including asthma, bronchitis, emphysema, and		obstructive lung diseases, including asth
IV.B.1.b).(1).(a).(xv)	bronchiectasis; (Core)	4.4.a.15.	bronchiectasis; (Core)
IV.B.1.b).(1).(a).(xvi)	occupational and environmental lung diseases; (Core)	4.4.a.16.	occupational and environmental lung dis
IV.B.1.b).(1).(a).(xvii)	peri-operative critically-ill patients, including hemodynamic and ventilatory support; (Core)	4.4.a.17.	peri-operative critically-ill patients, includ support; (Core)
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	psychosocial and emotional effects of critical illness on patients and patients'		psychosocial and emotional effects of cri
IV.B.1.b).(1).(a).(xviii)	families; (Core)	4.4.a.18.	families; (Core)
IV.B.1.b).(1).(a).(xix)	pulmonary embolism and pulmonary embolic disease; (Core)	4.4.a.19.	pulmonary embolism and pulmonary eml
, , , , , , , , , , , , , , , , ,	pulmonary infections, including tuberculous, fungal, and infections in the		pulmonary infections, including tuberculo
IV.B.1.b).(1).(a).(xx)	immunocompromised host (e.g., HIV-related infections); (Core)	4.4.a.20.	immunocompromised host (e.g., HIV-rela
IV.B.1.b).(1).(a).(xxi)	pulmonary malignancy, both primary and metastatic; (Core)	4.4.a.21.	pulmonary malignancy, both primary and
IV.B.1.b).(1).(a).(xxii)	pulmonary manifestations of systemic diseases, including collagen vascular disease and diseases that are primary in other organs; (Core)	4.4.a.22.	pulmonary manifestations of systemic dis disease and diseases that are primary in
IV.B.1.b).(1).(a).(xxiii)	pulmonary vascular disease, including pulmonary hypertension and the vasculitis and pulmonary hemorrhage syndromes;(Core)	4.4.a.23.	pulmonary vascular disease, including pu vasculitis and pulmonary hemorrhage sy
	renal disorders in the critical care unit, including electrolyte and acid-base disturbance and acute renal failure; (Core)	4.4.a.24.	renal disorders in the critical care unit, in disturbance and acute renal failure; (Cor

ent Language GME Competencies into the curriculum. Inalism nitment to professionalism and an ore) are and Procedural Skills (Part A) atient care that is patient- and familye, appropriate, and effective for the the promotion of health. (Core) ce in the evaluation, and management of

nhalation, and trauma; (Core) g overdosages and intoxication

is in the critical care unit; (Core) care unit; (Core)

and nosocomial problems in critical care

stinum; (Core) Core)

ng drug-induced disease; (Core)

ritical care unit; (Core)

ffects of critical illness, and hematologic with critical illness; (Core)

thma, bronchitis, emphysema, and

liseases; (Core)

uding hemodynamic and ventilatory

critical illness on patients and patients'

mbolic disease; (Core)

ulous, fungal, and infections in the elated infections); (Core)

nd metastatic; (Core)

diseases, including collagen vascular in other organs; (Core)

pulmonary hypertension and the

syndromes;(Core)

including electrolyte and acid-base ore)

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IV.B.1.b).(1).(a).(xxv)	respiratory failure, including the acute respiratory distress syndrome, acute and chronic respiratory failure in obstructive lung diseases, and neuromuscular respiratory drive disorders; (Core)	4.4.a.25.	respiratory failure, including the acute re- chronic respiratory failure in obstructive l respiratory drive disorders; (Core)
, , , , , , , ,	sepsis and septic shock; (Core)	4.4.a.26.	sepsis and septic shock; (Core)
	sever organ dysfunction resulting in critical illness, to include disorders of the endocrine, gastrointestinal, hematologic, immune, musculoskeletal, and neurologic, systems, as well as infections and malignancies; (Core)	4.4.a.27.	sever organ dysfunction resulting in critic endocrine, gastrointestinal, hematologic, neurologic, systems, as well as infections
	shock syndromes; and, (Core)	4.4.a.28.	shock syndromes; and, (Core)
	sleep-disordered breathing. (Core)	4.4.a.29.	sleep-disordered breathing. (Core)
IV.B.1.b).(2)	Fellows 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 Fellows must be able to perform all me procedures considered essential for t
IV.B.1.b).(2).(a)	Fellows must demonstrate competence in the ability to:	[None]	
IV.B.1.b).(2).(a).(i)	perform diagnostic and therapeutic procedures relevant to their specific career paths; and, (Core)	4.5.a.	Fellows must demonstrate competence in therapeutic procedures relevant to their s
IV.B.1.b).(2).(a).(ii)	treat their patients' conditions with practices that are patient-centered, safe, scientifically based, effective, timely, and cost-effective. (Core)	4.5.b.	Fellows must demonstrate competence in conditions with practices that are patient- effective, timely, and cost-effective. (Core
IV.B.1.b).(2).(b)	Fellows must demonstrate competence in interpreting data derived from various bedside devices commonly employed to monitor patients, and data from laboratory studies related to sputum, bronchopulmonary secretions, and pleural fluid. (Core)	4.5.c.	Fellows must demonstrate competence in bedside devices commonly employed to laboratory studies related to sputum, bro fluid. (Core)
IV.B.1.b).(2).(c)	Fellows must demonstrate competence in procedural and technical skills, including: (Core)	[None]	
IV.B.1.b).(2).(c).(i)	airway management; (Core)	4.5.d.	Fellows must demonstrate competence i including airway management. (Core)
			Fellows must demonstrate competence in including use of a variety of positive pres
IV.B.1.b).(2).(c).(ii)	use of a variety of positive pressure ventilatory modes, including: (Core)	4.5.e.	(Core)
, , , , , , , , , , , ,	initiation and maintenance of ventilatory support; (Detail) respiratory care techniques; and, (Detail)	4.5.e.1. 4.5.e.2.	initiation and maintenance of ventilatory s respiratory care techniques; and, (Detail)
······································	liberation from mechanical ventilatory support, including terminal extubation.	7.0.0.2.	liberation rom mechanical ventilatory sup
IV.B.1.b).(2).(c).(ii).(c)	(Detail)	4.5.e.3.	(Detail)
IV.B.1.b).(2).(c).(iii)	use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry; (Core)	4.5.f.	Fellows must demonstrate competence in including use of reservoir masks and con masks for delivery of supplemental oxyge incentive spirometry. (Core)
	flexible fiber-optic bronchoscopy procedures, including those in which endobronchial and transbronchial biopsies, and transbronchial needle aspiration are performed; (Core)	4.5.g.	Fellows must demonstrate competence in including flexible fiber-optic bronchoscop endobronchial and transbronchial biopsie are performed. (Core)
	pulmonary function tests to assess respiratory mechanics and gas exchange, including spirometry, flow volume studies, lung volumes, diffusing capacity, arterial blood gas analysis, exercise studies, and interpretation of the results of bronchoprovocation testing using methacholine or histamine; (Core)	4.5.h.	Fellows must demonstrate competence in including pulmonary function tests to ass exchange, including spirometry, flow volu capacity, arterial blood gas analysis, exe results of bronchoprovocation testing usin

respiratory distress syndrome, acute and e lung diseases, and neuromuscular

tical illness, to include disorders of the ic, immune, musculoskeletal, and ons and malignancies; (Core)

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

e in the ability to perform diagnostic and r specific career paths. (Core)

e in the ability to treat their patients' nt-centered, safe, scientifically based, ore)

e in interpreting data derived from various to monitor patients, and data from ronchopulmonary secretions, and pleural

e in procedural and technical skills,

e in procedural and technical skills, essure ventilatory modes, including:

y support; (Detail)

ail)

upport, including terminal extubation.

e in procedural and technical skills, ontinuous positive airway pressure /gen, humidifiers, nebulizers, and

e in procedural and technical skills, opy procedures, including those in which sies, and transbronchial needle aspiration

e in procedural and technical skills, ssess respiratory mechanics and gas olume studies, lung volumes, diffusing xercise studies, and interpretation of the using methacholine or histamine. (Core)

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IV.B.1.b).(2).(c).(vi)	diagnostic and therapeutic procedures, including paracentesis, lumbar puncture, thoracentesis, endotracheal intubation, and related procedures; (Core)	4.5.i.	Fellows must demonstrate competence including diagnostic and therapeutic proc puncture, thoracentesis, endotracheal in (Core)
IV.B.1.b).(2).(c).(vii)	placement and management of chest tubes and pleural drainage systems; (Core)	4.5.j.	Fellows must demonstrate competence i including placement and management of systems. (Core)
IV.B.1.b).(2).(c).(viii)	operation of bedside hemodynamic monitoring systems; (Core)	4.5.k.	Fellows must demonstrate competence i including operation of bedside hemodyna
IV.B.1.b).(2).(c).(ix)	emergency cardioversion; (Core)	4.5.I.	Fellows must demonstrate competence i including emergency cardioversion. (Cor
IV.B.1.b).(2).(c).(x)	interpretation of intracranial pressure monitoring; (Core)	4.5.m.	Fellows must demonstrate competence i including interpretation of intracranial pre
IV.B.1.b).(2).(c).(xi)	nutritional support; (Core)	4.5.n.	Fellows must demonstrate competence i including nutritional support. (Core)
IV.B.1.b).(2).(c).(xii)	those skills essential to critical care ultrasound, including image acquisition, image interpretation at the point of care, and use of ultrasound to place intravascular and intracavitary tubes and catheters; (Core)	4.5.0.	Fellows must demonstrate competence i including those skills essential to critical acquisition, image interpretation at the pe place intravascular and intracavitary tube
IV.B.1.b).(2).(c).(xiii)	use of transcutaneous pacemakers; and, (Core)	4.5.p.	Fellows must demonstrate competence i including use of transcutaneous pacema
IV.B.1.b).(2).(c).(xiv)	use of paralytic agents and sedative and analgesic drugs in the critical care unit. (Core)	4.5.q.	Fellows must demonstrate competence i including use of paralytic agents and sec care unit. (Core)
IV.B.1.c)	Medical Knowledge Fellows 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 Fellows must demonstrate knowledge biomedical, clinical, epidemiological, including scientific inquiry, as well as patient care. (Core)
IV.B.1.c).(1)	Fellows must demonstrate knowledge of the indications, contradictions, and complications of placement of arterial, central venous, and pulmonary artery balloon flotation catheters. (Core)	4.6.a.	Fellows must demonstrate knowledge of complications of placement of arterial, ce balloon flotation catheters. (Core)
IV.B.1.c).(2)	Fellows must demonstrate knowledge in the indications, contraindications, and complications of placement of percutaneous tracheostomies. (Core)	4.6.b.	Fellows must demonstrate knowledge in complications of placement of percutane
IV.B.1.c).(3)	Fellows must demonstrate knowledge of:	[None]	
IV.B.1.c).(3).(a)	imaging techniques commonly employed in the evaluation of patients with pulmonary disease or critical illness, including the technical and procedural use of ultrasound and interpretation of ultrasound images at the point of care for medical decision-making; (Core)	4.6.c.	Fellows must demonstrate knowledge of employed in the evaluation of patients w including the technical and procedural us ultrasound images at the point of care fo
IV.B.1.c).(3).(b)	monitoring and supervising special services, including: (Core)	4.6.d.	Fellows must demonstrate knowledge of services, including: (Core)
IV.B.1.c).(3).(b).(i)	respiratory care units; (Detail)	4.6.d.1.	respiratory care units; (Detail)
IV.B.1.c).(3).(b).(ii)	pulmonary function laboratories, including quality control, quality assurance, and proficiency standards; (Detail)	4.6.d.2.	pulmonary function laboratories, includin proficiency standards; (Detail)
IV.B.1.c).(3).(b).(iii)	respioratory care techniques and services. (Detail)	4.6.d.3.	respiratory care techniques and services

e in procedural and technical skills, rocedures, including paracentesis, lumbar intubation, and related procedures.

e in procedural and technical skills, of chest tubes and pleural drainage

e in procedural and technical skills, namic monitoring systems. (Core) e in procedural and technical skills, ore)

e in procedural and technical skills, pressure monitoring. (Core)

e in procedural and technical skills,

e in procedural and technical skills, al care ultrasound, including image point of care, and use of ultrasound to bes and catheters. (Core)

e in procedural and technical skills, nakers. (Core)

e in procedural and technical skills, edative and analgesic drugs in the critical

owledge

ge of established and evolving I, and social-behavioral sciences, as the application of this knowledge to

of the indications, contradictions, and central venous, and pulmonary artery

in the indications, contraindications, and neous tracheostomies. (Core)

of imaging techniques commonly with pulmonary disease or critical illness, use of ultrasound and interpretation of for medical decision-making. (Core) of monitoring and supervising special

ling quality control, quality assurance, and

es. (Detail)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
			Fellows must demonstrate knowledge of
, , , , , ,	the basic sciences, with particular emphasis on: (Core)	4.6.e.	emphasis on: (Core)
IV.B.1.c).(3).(c).(i)	genetics and molecular biology as they relate to pulmonary diseases; (Detail)	4.6.e.1.	genetics and molecular biology as they r
IV.B.1.c).(3).(c).(ii)	developmental biology; and, (Detail)	4.6.e.2.	developmental biology; and, (Detail)
IV.B.1.c).(3).(c).(iii)	pulmonary physiology and pathophysiology in systemic diseases. (Detail)	4.6.e.3.	pulmonary physiology and pathophysiology
IV.B.1.c).(3).(d)	biochemistry and physiology, including cell and molecular biology and immunology, as they relate to pulmonary disease; (Detail)	4.6.f.	Fellows must demonstrate knowledge of cell and molecular biology and immunolo disease. (Detail)
IV.B.1.c).(3).(e)	indications, complications, and outcomes of lung transplantation; (Core)	4.6.g.	Fellows must demonstrate knowledge of outcomes of lung transplantation. (Core)
IV.B.1.c).(3).(f)	pericardiocentesis; (Core)	4.6.h.	Fellows must demonstrate knowledge of
IV.B.1.c).(3).(g)	percutaneous needle biopsies; (Core)	4.6.i.	Fellows must demonstrate knowledge of
IV.B.1.c).(3).(h)	renal replacement therapy; (Core)	4.6.j.	Fellows must demonstrate knowledge of
IV.B.1.c).(3).(i)	pharmacokinetics, pharmacodynamics, and drug metabolism and excretion in critical illness; (Core)	4.6.k.	Fellows must demonstrate knowledge of and drug metabolism and excretion in cr
IV.B.1.c).(3).(j)	principles and techniques of administration and management of a MICU; (Core)	4.6.l.	Fellows must demonstrate knowledge of administration and management of a MIC
IV.B.1.c).(3).(k)	ethical, economic, and legal aspects of critical illness; (Core)	4.6.m.	Fellows must demonstrate knowledge of critical illness. (Core)
IV.B.1.c).(3).(I)	recognition and management of the critically ill from disasters, including those caused by chemical and biological agents; and, (Core)	4.6.n.	Fellows must demonstrate knowledge of critically ill from disasters, including those agents. (Core)
IV.B.1.c).(3).(m)	the psychosocial and emotional effects of critical illness on patients and patients' families. (Core)	4.6.0.	Fellows must demonstrate knowledge of of critical illness on patients and patients
	Practice-based Learning and Improvement Fellows 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 Fellows must demonstrate the ability of patients, to appraise and assimilate continuously improve patient care bas lifelong learning. (Core)
IV.B.1.e)	Interpersonal and Communication Skills Fellows 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 Fellows must demonstrate interperso result in the effective exchange of info patients, their families, and health pro
	Systems-based Practice Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)	4.9.	ACGME Competencies – Systems-Bas Fellows must demonstrate an awaren larger context and system of health ca social determinants of health, as well other resources to provide optimal he

of the basic sciences, with particular

relate to pulmonary diseases; (Detail)

ology in systemic diseases. (Detail)

of biochemistry and physiology, including blogy, as they relate to pulmonary

of indications, complications, and e)

of pericardiocentesis. (Core)

of percutaneous needle biopsies. (Core) of renal replacement therapy. (Core)

of pharmacokinetics, pharmacodynamics, critical illness. (Core)

of principles and techniques of /ICU. (Core)

of ethical, economic, and legal aspects of

of recognition and management of the ose caused by chemical and biological

of the psychosocial and emotional effects ats' families. (Core)

ased Learning and Improvement y to investigate and evaluate their care ate scientific evidence, and to based on constant self-evaluation and

nal and Communication Skills sonal and communication skills that nformation and collaboration with rofessionals. (Core)

ased Practice

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
IV.C.	Curriculum Organization and Fellow Experiences	4.10 4.12.	Curriculum Organization and Fellow E 4.10. Curriculum Structure The curriculum must be structured to experiences, the length of the experie continuity. These educational experie supervised patient care responsibilitie educational events. (Core) 4.11. Didactic and Clinical Experience Fellows must be provided with protect didactic activities. (Core) 4.12. Pain Management The program must provide instruction management if applicable for the subst the signs of substance use disorder.
IV.C.1.	The curriculum must be structured to optimize fellow educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)	4.10.	Curriculum Structure The curriculum must be structured to experiences, the length of the experie continuity. These educational experie supervised patient care responsibilitie educational events. (Core)
IV.C.1.a)	Rotations must be of sufficient length to provide longitudinal relationships with faculty members to allow for meaningful assessment and feedback. (Core)	4.10.a.	Rotations must be of sufficient length to faculty members to allow for meaningful
IV.C.1.b)	Rotations must be structured to allow fellows to function as part of an effective interprofessional team that works together towards the shared goals of patient safety and quality improvement. (Core)	4.10.b.	Rotations must be structured to allow fell interprofessional team that works togethe safety and quality improvement. (Core)
IV.C.1.c)	Schedules must be structured to minimize conflicting inpatient and outpatient responsibilities. (Core)	4.10.c.	Schedules must be structured to minimiz responsibilities. (Core)
IV.C.2.	The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of substance use disorder. (Core)	4.12.	Pain Management The program must provide instruction management if applicable for the subs the signs of substance use disorder.
IV.C.3.	The program must provide opportunities to manage adult patients with a wide variety of serious illnesses and injuries requiring treatment in a critical care setting. (Detail)	4.11.a.	The program must provide opportunities variety of serious illnesses and injuries resetting. (Detail)
IV.C.4.	Fellows must have at least 18 months of clinical experience, including: (Core)	4.11.b.	Fellows must have at least 18 months of
IV.C.4.a)	at least nine months of patient care responsibility for inpatients and outpatients with a wide variety of pulmonary diseases, with an educational emphasis on pulmonary physiology and its correlation with clinical disorders; (Core)	4.11.b.1.	at least nine months of patient care resp with a wide variety of pulmonary disease pulmonary physiology and its correlation
IV.C.4.b)	at least nine months in critical care medicine, of which at least six months must be devoted to the care of critically ill medical patients (MICU/CICU or equivalent); (Core)	4.11.b.2.	at least nine months in critical care medi- be devoted to the care of critically ill med equivalent); (Core)

nt Language **Experiences** to optimize fellow educational iences, and the supervisory iences include an appropriate blend of ties, clinical teaching, and didactic ces ected time to participate in core on and experience in pain bspecialty, including recognition of (Core) to optimize fellow educational iences, and the supervisory iences include an appropriate blend of ties, clinical teaching, and didactic o provide longitudinal relationships with al assessment and feedback. (Core) ellows to function as part of an effective ther towards the shared goals of patient nize conflicting inpatient and outpatient on and experience in pain bspecialty, including recognition of (Core) es to manage adult patients with a wide requiring treatment in a critical care of clinical experience, including: (Core) sponsibility for inpatients and outpatients ses, with an educational emphasis on on with clinical disorders; (Core) dicine, of which at least six months must

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
IV.C.4.c)	at least three months devoted to the care of critically ill non-medical patients (SICU, Burn Unit, Transplant Unit, Neurointensive Care, or equivalent); and, (Core)	4.11.b.3.	at least three months devoted to the care (SICU, Burn Unit, Transplant Unit, Neuro
IV.C.4.c).(1)	This experience should consist of at least one month of direct patient care activity, with the remainder being fulfilled by either consultative activities or in direct care of such patients. (Detail)	4.11.b.3.a.	This experience should consist of at leas activity, with the remainder being fulfilled direct care of such patients. (Detail)
IV.C.4.d)	not more than 15 months of required intensive care unit experiences in the three years of the educational program. (Detail)	4.11.b.4.	no more than 15 months of required inte years of the educational program. (Detai
IV.C.5.	Fellow experiences must include:	[None]	
IV.C.5.a)	continuing responsibility for both acutely and chronically ill pulmonary patients, in order to learn both the natural history of pulmonary disease and the effectiveness of therapeutic programs; (Core)	4.11.c.	Fellows experiences must include contin chronically ill pulmonary patients, in orde pulmonary disease and the effectiveness
IV.C.5.b)	managing adult patients with a wide variety of serious illnesses and injuries requiring treatment in a critical care setting; and, (Core)	4.11.d.	Fellows experiences must include mana serious illnesses and injuries requiring tr
IV.C.5.c)	clinical experience in the evaluation and management of patients: (Core)	4.11.e.	Fellow experiences must include clinical management of patients: (Core)
IV.C.5.c).(1)	with genetic and developmental disorders of the respiratory system, including cystic fibrosis; (Detail)	4.11.e.1.	with genetic and developmental disorder cystic fibrosis; (Detail)
IV.C.5.c).(2)	undergoing pulmonary rehabilitation; (Core)	4.11.e.2.	undergoing pulmonary rehabilitation; (Co
IV.C.5.c).(3)	with trauma; (Core)	4.11.e.3.	with trauma; (Core)
IV.C.5.c).(4)	with neurosurgical emergencies; (Core)	4.11.e.4.	with neurosurgical emergencies; (Core)
IV.C.5.c).(5)	with critical obstetric and gynecologic disorders; and, (Core)	4.11.e.5.	with critical obstetric and gynecologic dis
IV.C.5.c).(6)	after discharge from the critical care unit. (Core)	4.11.e.6.	after discharge from the critical care unit
IV.C.6.	Fellows must have clinical experience in examination and interpretation of lung tissue for infectious agents, cytology, and histopathology. (Core)	4.11.f.	Fellows must have clinical experience in tissue for infectious agents, cytology, and
IV.C.7.	Experience with Continuity Ambulatory Patients	[None]	
IV.C.7.a)	Fellows must have continuity ambulatory clinic experience for the duration of the program that exposes them to the breadth and depth of the subspecialty. (Core)		Experience with Continuity Ambulatory F Fellows must have continuity ambulatory program that exposes them to the bread
IV.C.7.a).(1)	For programs with at least 24 months of clinical rotations, fellows must complete a minimum of 24 months of one half-day weekly ambulatory care clinic experience during the 36-month fellowship. (Detail)	4.11.g.1.	For programs with at least 24 months of a minimum of 24 months of one half-day experience during the 36-month fellowsh
IV.C.7.a).(2)	For programs with 18-23 months of required clinical rotations, fellows must complete a minimum of 30 months of one half-day weekly ambulatory care clinic experience during the 36-month fellowship. (Detail)	4.11.g.2.	For programs with 18-23 months of requ complete a minimum of 30 months of on experience during the 36-month fellowsh
IV.C.7.b)	Each fellow should be responsible, on average, for four to eight patients during each half day session. (Detail)	4.11.g.3.	Each fellow should be responsible, on av each half day session. (Detail)
IV.C.7.c)	Fellows may be exempted from ambulatory experiences during MICU rotations, other time-intensive rotations, or vacation. These exemptions must not exceed a total of six months. (Detail)	4.11.g.4.	Fellows may be exempted from ambulate other time-intensive rotations, or vacation total of six months. (Detail)
IV.C.8.	Fellows must have experience in managing patients with tracheostomies, including their specific complications. (Detail)	4.11.h.	Fellows must have experience in manag including their specific complications. (De
IV.C.9.	Fellows must have experience in the role of a pulmonary disease consultant in both the inpatient and outpatient settings and as a critical care medicine consultant in the inpatient setting. (Core)	4.11.i.	Fellows must have experience in the role both the inpatient and outpatient settings consultant in the inpatient setting. (Core)

are of critically ill non-medical patients irointensive Care, or equivalent); (Core)

ast one month of direct patient care ed by either consultative activities or in

tensive care unit experiences in the three tail)

tinuing responsibility for both acutely and der to learn both the natural history of ess of therapeutic programs. (Core) naging adult patients with a wide variety of

treatment in a critical care setting. (Core) al experience in the evaluation and

ers of the respiratory system, including

Core)

lisorders; and, (Core)

nit. (Core)

in examination and interpretation of lung and histopathology. (Core)

Patients

bry clinic experience for the duration of the adth and depth of the subspecialty. (Core)

of clinical rotations, fellows must complete ay weekly ambulatory care clinic ship. (Detail)

quired clinical rotations, fellows must one half-day weekly ambulatory care clinic ship. (Detail)

average, for four to eight patients during

atory experiences during MICU rotations, ion. These exemptions must not exceed a

aging patients with tracheostomies, Detail)

ble of a pulmonary disease consultant in gs and as a critical care medicine e)

Roman Numeral		Reformatted	
Requirement Number		Requirement Number	
	The educational program must provide fellows with individualized educational experiences to allow them to participate in opportunities relevant to their future		The educational program must provide fellows with individualized educational experiences to allow them to participate in opportunities relevant to their future
	practice or to further skill/competence development in the foundational		practice or to further skill/competence development in the foundational
IV.C.10.	educational experiences of the subspecialty. (Core)	4.11.j.	educational experiences of the subspecialty. (Core)
	Direct supervision of procedures performed by each fellow must occur until		Direct supervision of procedures performed by each fellow must occur until
IV.C.11.	proficiency has been acquired and documented by the program director. (Core)	4.11.k.	proficiency has been acquired and documented by the program director. (Core)
	Faculty members must teach and supervise the fellows in the performance and		Faculty members must teach and supervise the fellows in the performance and
	interpretation of procedures, which must be documented in each fellow's record,		interpretation of procedures, which must be documented in each fellow's record,
IV.C.12.	including indications, outcomes, diagnoses, and supervisor(s). (Core)	4.11.l.	including indications, outcomes, diagnoses, and supervisor(s). (Core)
			Required Didactic Experience
			The educational program must include didactic instruction based on the core
IV.C.13.	Required Didactic Experience	4.11.m.	knowledge content in the subspecialty area. (Core)
			Required Didactic Experience
	The educational program must include didactic instruction based on the core		The educational program must include didactic instruction based on the core
IV.C.13.a)	knowledge content in the subspecialty area. (Core)	4.11.m.	knowledge content in the subspecialty area. (Core)
	The program must ensure that fellows have an opportunity to review all content		The program must ensure that fellows have an opportunity to review all content
IV.C.13.a).(1)	from conferences that they could not attend. (Core)	4.11.m.1.	from conferences that they could not attend. (Core)
	Fellows must have a sufficient number of didactic sessions to ensure fellow-		Fellows must have a sufficient number of didactic sessions to ensure fellow-
IV.C.13.b)	fellow and fellow-faculty interaction. (Core)	4.11.m.2.	fellow and fellow-faculty interaction. (Core)
	Fellows must be provided a patient- or case-based to clinical teaching that includes interactions between fellows and the teaching faculty member, bedside teaching, discussion of pathophysiology, and the application of current evidence		Fellows must be provided a patient- or case-based to clinical teaching that
	in diagnostic and therapeutic decisions. (Core)		includes interactions between fellows and the teaching faculty member, bedside teaching, discussion of pathophysiology, and the application of current evidence
IV.C.14.	The teaching must occur:	4.11.n.	in diagnostic and therapeutic decisions. (Core)
			The teaching must occur with a frequency and duration to ensure a meaningful
	with a frequency and duration to ensure a meaningful teaching relationship		teaching relationship between the assigned teaching faculty member and the
IV.C.14.a)	between the assigned teaching faculty member and the fellow; and, (Core)	4.11.n.1.	fellow. (Core)
IV.C.14.b)	on all inpatient, telemedicine, and consultative services. (Core)	4.11.n.2.	The teaching must occur on all inpatient, telemedicine, and consultative services. (Core)
	Fellows must receive instruction in practice management relevant to the		Fellows must receive instruction in practice management relevant to the
IV.C.15.	subspecialty. (Detail)	4.11.o.	subspecialty. (Detail)

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Requirement Number	Requirement Language	Requirement Number	Requiremen
	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 fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching. The ACGME recognizes the diversity of fellowships and anticipates that		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 as Program Requirements. Scholarly activities integration, application, and teaching
IV.D.	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, ar serves. For example, some programs activity on quality improvement, popu other programs might choose to utiliz research as the focus for scholarship
IV.D.1.	Program Responsibilities	4.13.	Program Responsibilities The program must demonstrate evide consistent with its mission(s) and ain
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 consistent with its mission(s) and ain
IV.D.1.b)	The program in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate fellow and faculty involvement in scholarly activities. (Core)	4.13.a.	The program in partnership with its S adequate resources to facilitate fellow scholarly activities. (Core)
			Faculty Scholarly Activity Among their scholarly activity, progra accomplishments in at least three of t •Research in basic science, education or population health •Peer-reviewed grants •Quality improvement and/or patient s •Systematic reviews, meta-analyses, t textbooks, or case reports •Creation of curricula, evaluation tool 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 fellow as defined in the subspecialty-specific activities may include discovery, ng.

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

dence of scholarly activities, aims. (Core)

dence of scholarly activities, aims. (Core)

Sponsoring Institution, must allocate ow and faculty involvement in

grams must demonstrate of the following domains: (Core) ion, translational science, patient care,

it safety initiatives s, review articles, chapters in medical

ools, didactic educational activities, or

nittees, educational organizations, or

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Requirement Number	Requirement Language	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		•Research in basic science, education or population health
	•Peer-reviewed grants		•Peer-reviewed grants
	•Quality improvement and/or patient safety initiatives		•Quality improvement and/or patient s
	•Systematic reviews, meta-analyses, review articles, chapters in medical		•Systematic reviews, meta-analyses, r
	textbooks, or case reports		textbooks, or case reports
	•Creation of curricula, evaluation tools, didactic educational activities, or		 Creation of curricula, evaluation tool
	electronic educational materials		electronic educational materials
	•Contribution to professional committees, educational organizations, or		•Contribution to professional committ
	editorial boards		editorial boards
IV.D.2.a)	•Innovations in education	4.14.	•Innovations in education
IV.D.2.b)	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:	4.14.a.	The program must demonstrate disse and external to the program by the fol
IV.D.2.b).(1)	faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non- peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor. (Outcome)	4.14.a.1.	faculty participation in grand rounds, improvement presentations, podium p peer-reviewed print/electronic resourc chapters, textbooks, webinars, service serving as a journal reviewer, journal (Outcome)
IV.D.2.b).(1).(a)	At least 50 percent of the core faculty members who are certified in critical care medicine or pulmonary disease by the ABIM or AOBIM (see Program Requirements II.B.4.b)-c)) must annually engage in a variety of scholarly activities, as listed in Program Requirement IV.D.2.b).(1). (Core)	4.14.a.1.a.	At least 50 percent of the core faculty me medicine or pulmonary disease by the A Requirements 2.10.bc.) must annually activities, as listed in Program Requirem
IV.D.3.	Fellow Scholarly Activity	4.15.	Fellow Scholarly Activity While in the program all fellows must end scholarly activities: participation in grand improvement presentations, podium prese reviewed print/electronic resources, artic textbooks, webinars, service on profession reviewer, journal editorial board member
			Fellow Scholarly Activity
	While in the program all fellows must engage in at least one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal		While in the program all fellows must eng scholarly activities: participation in grand improvement presentations, podium pres reviewed print/electronic resources, artic textbooks, webinars, service on profession
IV.D.3.a)	reviewer, journal editorial board member, or editor. (Outcome)	4.15.	reviewer, journal editorial board member
V.	Evaluation	Section 5	Section 5: Evaluation
			Fellow Evaluation: Feedback and Eva Faculty members must directly obser feedback on fellow performance durir
V.A.	Fellow Evaluation	5.1.	educational assignment. (Core)

rams must demonstrate f the following domains: (Core) on, translational science, patient care,

t safety initiatives , review articles, chapters in medical

ols, didactic educational activities, or

ittees, educational organizations, or

semination of scholarly activity within following methods:

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

members who are certified in critical care ABIM or AOBIM (see Program y engage in a variety of scholarly ment 4.14.a.1. (Core)

engage in at least one of the following nd rounds, posters, workshops, quality resentations, grant leadership, non-peerticles or publications, book chapters, sional committees, or serving as a journal er, or editor. (Outcome)

engage in at least one of the following nd rounds, posters, workshops, quality resentations, grant leadership, non-peerticles or publications, book chapters, sional committees, or serving as a journal er, or editor. (Outcome)

aluation

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
·		·	Fellow Evaluation: Feedback and Eva Faculty members must directly obser feedback on fellow performance durir
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 fellow performance during each rotation or similar educational assignment. (Core)	5.1.	Fellow Evaluation: Feedback and Eva Faculty members must directly observ feedback on fellow performance durin educational assignment. (Core)
V.A.1.a).(1)	Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed. (Detail)	5.1.h.	Assessment of procedural competence s process and not be based solely on a mi performed. (Detail)
V.A.1.b)	Evaluation must be documented at the completion of the assignment. (Core)	5.1.a.	Evaluation must be documented at the (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 thr must be documented at least every th
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 cor clinical responsibilities must be evalu at completion. (Core)
V.A.1.c)	The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: (Core)	5.1.b.	The program must provide an objective the Competencies and the subspecial (Core)
V.A.1.c).(1)	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)	5.1.b.1.	use multiple evaluators (e.g., faculty r other professional staff members); an
V.A.1.c).(2)	provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice. (Core)	5.1.b.2.	provide that information to the Clinica synthesis of progressive fellow perfor unsupervised practice. (Core)
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 fellow their documented semi-annual evaluation of performance, including progress along the subspecialty- specific Milestones; (Core)	5.1.c.	The program director or their designe Competency Committee, must meet w documented semi-annual evaluation of along the subspecialty-specific Milest
V.A.1.d).(2)	assist fellows 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 learning plans to capitalize on their st growth. (Core)
V.A.1.d).(3)	develop plans for fellows 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 fellow 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.f)	The evaluations of a fellow's performance must be accessible for review by the fellow. (Core)	5.1.g.	The evaluations of a fellow's performa by the fellow. (Core)
V.A.2.	Final Evaluation	5.2.	Fellow Evaluation: Final Evaluation The program director must provide a completion of the program. (Core)

aluation

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

aluation

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

e should include a formal evaluation minimum number of procedures

the completion of the assignment.

hree months in duration, evaluation three months. (Core)

ontinuity clinic in the context of other luated at least every three months and

tive performance evaluation based on alty-specific Milestones, and must:

r members, peers, patients, self, and and, (Core)

cal Competency Committee for its formance and improvement toward

nee, with input from the Clinical with and review with each fellow their of performance, including progress stones. (Core)

nee, with input from the Clinical at fellows in developing individualized strengths and identify areas for

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

ummative evaluation of each fellow press to the next year of the program, if

mance must be accessible for review

a final evaluation for each fellow upon

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
V.A.2.a)	The program director must provide a final evaluation for each fellow upon completion of the program. (Core)	5.2.	Fellow Evaluation: Final Evaluation The program director must provide a completion of the program. (Core)
V.A.2.a).(1)	The subspecialty-specific Milestones, and when applicable the subspecialty-specific Case Logs, must be used as tools to ensure fellows are able to engage in autonomous practice upon completion of the program. (Core)	5.2.a.	The subspecialty-specific Milestones, subspecialty-specific Case Logs, mus are able to engage in autonomous pra program. (Core)
V.A.2.a).(2)	The final evaluation must: become part of the fellow's permanent record maintained by the	[None]	The final evaluation must become par
V.A.2.a).(2).(a)	institution, and must be accessible for review by the fellow in accordance with institutional policy; (Core)	5.2.b.	fellow in accordance with institutional
V.A.2.a).(2).(b)	verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	The final evaluation must verify that th knowledge, skills, and behaviors nece (Core)
V.A.2.a).(2).(c)	be shared with the fellow upon completion of the program. (Core)	5.2.d.	The final evaluation must be shared w 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, at least one of whom is a core faculty member. 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 fellows. (Core)	5.3.a.	At a minimum the Clinical Competenc members, at least one of whom is a co be faculty members from the same pro health professionals who have extens program's fellows. (Core)
V.A.3.b)	The Clinical Competency Committee must:	[None]	
V.A.3.b).(1)	review all fellow evaluations at least semi-annually; (Core)	5.3.b.	The Clinical Competency Committee r least semi-annually. (Core)
V.A.3.b).(2)	determine each fellow's progress on achievement of the subspecialty- specific Milestones; and, (Core)	5.3.c.	The Clinical Competency Committee r progress on achievement of the subs
V.A.3.b).(3)	meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (Core)	5.3.d.	The Clinical Competency Committee r annual evaluations and advise the pro fellow's progress. (Core)
V.B.	Faculty Evaluation	5.4.	Faculty Evaluation The program must have a process to o 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 o performance as it relates to the educa (Core)
V B 1 2)	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. (Coro)		This evaluation must include a review teaching abilities, engagement with th in faculty development related to their performance, professionalism, and so
V.B.1.a) V.B.1.b)	performance, professionalism, and scholarly activities. (Core) This evaluation must include written, confidential evaluations by the fellows. (Core)	5.4.a. 5.4.b.	performance, professionalism, and sc This evaluation must include written, fellows. (Core)

a final evaluation for each fellow upon

es, and when applicable the ust be used as tools to ensure fellows practice upon completion of the

art of the fellow's permanent record ust be accessible for review by the nal policy. (Core)

the fellow has demonstrated the cessary to enter autonomous practice.

with the fellow upon completion of the

nust be appointed by the program

ncy Committee must include three core faculty member. Members must program or other programs, or other nsive contact and experience with the

e must review all fellow evaluations at

e must determine each fellow's specialty-specific Milestones. (Core)

e must meet prior to the fellows' semirogram 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, confidential evaluations by the

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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 the conduct and document the Annual Pro program's continuous improvement p
V.C.1	The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)	5.5.	Program Evaluation and Improvement The program director must appoint th conduct and document the Annual Pro program's continuous improvement p
	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member,	5 5 -	The Program Evaluation Committee m program faculty members, at least one
V.C.1.a)	and at least one fellow. (Core) Program Evaluation Committee responsibilities must include:	5.5.a.	and at least one fellow. (Core)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	Drogram Evoluction Committee reserve
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 respo program's self-determined goals and (Core)
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee respo ongoing program improvement, inclue 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 respo current operating environment to iden opportunities, and threats as related t (Core)
V.C.1.c)	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate fellow 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 sl prior Annual Program Evaluation(s), a evaluations of the program, and other 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 m and aims, strengths, areas for improve
V.C.1.e)	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the fellows and the members of the teaching faculty, and be submitted to the DIO. (Core)	5.5.g.	The Annual Program Evaluation, inclu distributed to and discussed with the teaching faculty, and be submitted to
V.C.2.	The program must participate in a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must participate in a Sel (Core)
	One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic		Board Certification One goal of ACGME-accredited educa seek and achieve board certification. the educational program is the ultimat The program director should encoura take the certifying examination offered of Medical Specialties (ABMS) membe
V.C.3.	Association (AOA) certifying board.	[None]	Association (AOA) certifying board.

back on their evaluations at least

valuations should be incorporated into plans. (Core)

nt

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

nt

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 discussion of the discuss

oonsibilities must include guiding uding development of new goals,

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

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

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

luding the action plan, must be e fellows and the members of the o the DIO. (Core)

elf-Study and submit it to the DIO.

cation is to educate physicians who a. 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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
V.C.3.a)	For subspecialties 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 subspecialty. (Outcome)		Board Certification For subspecialties in which the ABMS certifying board offer(s) an annual wri years, the program's aggregate pass for the first time must be higher than t programs in that subspecialty. (Outco
V.C.3.b)	For subspecialties 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 subspecialty. (Outcome)	5.6.a.	For subspecialties in which the ABMS certifying board offer(s) a biennial wri years, the program's aggregate pass for the first time must be higher than t programs in that subspecialty. (Outco
V.C.3.c)	For subspecialties 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 subspecialty. (Outcome)		For subspecialties in which the ABMS certifying board offer(s) an annual ora the program's aggregate pass rate of first time must be higher than the bott that subspecialty. (Outcome)
V.C.3.d)	For subspecialties 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 subspecialty. (Outcome)		For subspecialties in which the ABMS certifying board offer(s) a biennial ora the program's aggregate pass rate of first time must be higher than the bott that subspecialty. (Outcome)
V.C.3.e)	For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty. (Outcome)		For each of the exams referenced in 5 graduates over the time period specifi an 80 percent pass rate will have met percentile rank of the program for pas (Outcome)
V.C.3.f)	Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier. (Core)	5.6.e.	Programs must report, in ADS, board cohort of board-eligible fellows that g

IS member board and/or AOA written exam, in the preceding three s rate of those taking the examination n the bottom fifth percentile of come)

AS member board and/or AOA written exam, in the preceding six s rate of those taking the examination n the bottom fifth percentile of come)

AS member board and/or AOA oral exam, in the preceding three years, of those taking the examination for the ottom fifth percentile of programs in

AS member board and/or AOA oral exam, in the preceding six years, of those taking the examination for the ottom fifth percentile of programs in

1 5.6. – 5.6.c., any program whose cified in the requirement have achieved et this requirement, no matter the ass rate in that subspecialty.

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

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			Section 6: The Learning and Working
	The Learning and Working Environment		
			The Learning and Working Environme
	Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:		Fellowship education must occur in the environment that emphasizes the following the f
	•Excellence in the safety and quality of care rendered to patients by fellows today		•Excellence in the safety and quality of fellows today
	•Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice		•Excellence in the safety and quality of today's fellows in their future practice
	•Excellence in professionalism		•Excellence in professionalism
	•Appreciation for the privilege of providing care for patients		•Appreciation for the privilege of prov
	•Commitment to the well-being of the students, residents, fellows, faculty		•Commitment to the well-being of the
	members, and all members of the health care team		members, and all members of the hea
VI. VI.A.	Patient Safety, Quality Improvement, Supervision, and Assountability	Section 6	
VI.A.1.	Patient Safety, Quality Improvement, Supervision, and Accountability Patient Safety and Quality Improvement	[None] [None]	
VI.A.1.a)	Patient Safety	[None]	
vi.A. i.a)			
	Culture of Safety		
	A culture of safety requires continuous identification of vulnerabilities		Culture of Safety 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 safe
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 experiential learning are essential to developing true competence in		and are essential for the success of a and experiential learning are essentia
	the ability to identify causes and institute sustainable systems-based		the ability to identify causes and insti
VI.A.1.a).(2)	changes to ameliorate patient safety vulnerabilities.	[None]	changes to ameliorate patient safety
, , ,	Residents, fellows, faculty members, and other clinical staff members		
VI.A.1.a).(2).(a)	must:	[None]	
			Residents, fellows, faculty members,
	know their responsibilities in reporting patient safety events and unsafe		must know their responsibilities in re
	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)

g Environment

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the context of a learning and working lowing principles:

of care rendered to patients by

v of care rendered to patients by ce

oviding care for patients

e students, residents, fellows, faculty ealth care team

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 ite to a culture of safety. (Core)

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

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiremen
			Residents, fellows, faculty members,
	be provided with summary information of their institution's patient safety		must be provided with summary infor
VI.A.1.a).(2).(a).(ii)	reports. (Core)	6.2.a.	safety reports. (Core)
	Fellows must participate as team members in real and/or simulated		Fellows must participate as team mer
	interprofessional clinical patient safety and quality improvement activities,		interprofessional clinical patient safe
$(1 \land 4 \land (2) \land (2))$	such as root cause analyses or other activities that include analysis, as	C 2	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		Access to data is essential to prioritiz
VI.A.1.a).(3)	and evaluating success of improvement efforts.	[None]	and evaluating success of improvement
	Fellows and faculty members must receive data on quality metrics and		Fellows and faculty members must re
VI.A.1.a).(3).(a)	benchmarks related to their patient populations. (Core)	6.4.	benchmarks related to their patient pe
			Supervision and Accountability
			Although the attending physician is u
			the patient, every physician shares in
			accountability for their efforts in the p
			in partnership with their Sponsoring l
			communicate, and monitor a structur
			accountability as it relates to the supe
			Supervision in the setting of graduate
			and effective care to patients; ensure
			skills, knowledge, and attitudes requi
			practice of medicine; and establishes
VI.A.2.	Supervision and Accountability	[None]	professional growth.
			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		the patient, every physician shares in
	accountability for their efforts in the provision of care. Effective programs,		accountability for their efforts in the p
	in partnership with their Sponsoring Institutions, define, widely		in partnership with their Sponsoring I
	communicate, and monitor a structured chain of responsibility and		communicate, and monitor a structur
	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
l	and effective care to patients; ensures each fellow's development of the		and effective care to patients; ensure
l	skills, knowledge, and attitudes required to enter the unsupervised		skills, knowledge, and attitudes requi
l	practice of medicine; and establishes a foundation for continued		practice of medicine; and establishes
VI.A.2.a)	professional growth.	[None]	professional growth.
			Fellows and faculty members must in
			roles in that patient's care when prov
	Fellows and faculty members must inform each patient of their respective	C 5	information must be available to fello
VI.A.2.a).(1)	roles in that patient's care when providing direct patient care. (Core)	6.5.	of the health care team, and patients.
			Fellows and faculty members must in
	This information must be available to fellows, faculty members, other		roles in that patient's care when prov information must be available to fello
VI.A.2.a).(1).(a)	members of the health care team, and patients. (Core)	6.5.	of the health care team, and patients.

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

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

tizing activities for care improvement ment efforts.

receive data on quality metrics and populations. (Core)

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

nte medical education provides safe res each fellow'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 programs, Institutions, define, widely ured chain of responsibility and pervision of all patient care.

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

inform each patient of their respective oviding direct patient care. This lows, faculty members, other members s. (Core)

inform each patient of their respective oviding direct patient care. This lows, faculty members, other members s. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
VI.A.2.a).(2)	The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)	6.6.	The program must demonstrate that the program must demonstrate that the place for all fellows is based on each as well as patient complexity and acuit through a variety of methods, as approved the provide the providet the pr
VI.A.2.b)	Levels of Supervision To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:	[None]	Levels of Supervision To promote appropriate fellow superv authority and responsibility, the progr classification of supervision.
			Direct Supervision The supervising physician is physical key portions of the patient interaction.
VI.A.2.b).(1)	Direct Supervision:	6.7.	The supervising physician and/or pati the fellow and the supervising physici patient care through appropriate telec
,,,,			Direct Supervision The supervising physician is physical key portions of the patient interaction
VI.A.2.b).(1).(a)	the supervising physician is physically present with the fellow during the key portions of the patient interaction; or,	6.7.	The supervising physician and/or pati the fellow and the supervising physici patient care through appropriate telec
			Direct Supervision The supervising physician is physical key portions of the patient interaction
VI.A.2.b).(1).(b)	the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.	6.7.	The supervising physician and/or pati the fellow and the supervising physici patient care through appropriate telec
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 fellow 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 fellow must be assigned by the program director and faculty members. (Core)	6.9.	The privilege of progressive authority independence, and a supervisory role fellow must be assigned by the progra (Core)
VI.A.2.d).(1)	The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. (Core)	6.9.a.	The program director must evaluate expecific criteria, guided by the Milesto

t the appropriate level of supervision in h fellow's level of training and ability, cuity. Supervision may be exercised propriate to the situation. (Core)

rvision while providing for graded gram must use the following

cally present with the fellow during the on.

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

cally present with the fellow during the on.

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

cally present with the fellow during the on.

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

oviding physical or concurrent visual tely available to the fellow 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 gram director and faculty members.

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

Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requirement
VI A 2 d) (2)	Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)	6.9.b.	Faculty members functioning as supe portions of care to fellows based on the of each fellow. (Core)
VI.A.2.d).(2)	Fellows should serve in a supervisory role to junior fellows and residents	0.9.0.	Fellows should serve in a supervisory
VI.A.2.d).(3)	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.	in recognition of their progress toward of each patient and the skills of the in
VI.A.2.e)	Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)	6.10.	Programs must set guidelines for circ fellows must communicate with the su
VI.A.2.e).(1)	Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. (Outcome)	6.10.a.	Each fellow must know the limits of the circumstances under which the fellow independence. (Outcome)
VI.A.2.f)	Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility. (Core)	6.11.	Faculty supervision assignments mus the knowledge and skills of each fello appropriate level of patient care autho
VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with their Sp fellows and faculty members concern responsibilities of physicians, includi to be appropriately rested and fit to po patients. (Core)
VI.B.1.	Programs, in partnership with their Sponsoring Institutions, must educate fellows 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 fellows and faculty members concern responsibilities of physicians, includi to be appropriately rested and fit to po patients. (Core)
VI.B.2.	The learning objectives of the program must:	[None]	
VI.B.2.a)	be accomplished without excessive reliance on fellows to fulfill non- physician obligations; (Core)	6.12.a.	The learning objectives of the programe excessive reliance on fellows to fulfill
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 fellow 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 fellow finds in including protecting time with patients promoting progressive independence professional relationships. (Core)
VI.B.3.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)	6.12.d.	The program director, in partnership v provide a culture of professionalism t personal responsibility. (Core)
VI.B.4.	Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)	6.12.e.	Fellows and faculty members must de personal role in the safety and welfare including the ability to report unsafe o
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, fellows, faculty, and staff. (Core)	6.12.f.	Programs, in partnership with their Sp a professional, equitable, respectful, a psychologically safe and that is free fi forms of harassment, mistreatment, a fellows, faculty, and staff. (Core)

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

ry role to junior fellows and residents ard independence, based on the needs individual resident or fellow. (Detail) rcumstances and events in which

supervising faculty member(s). (Core)

their scope of authority, and the ow is permitted to act with conditional

ust be of sufficient duration to assess low and to delegate to the fellow the hority and responsibility. (Core)

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

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

am must be accomplished without ill non-physician obligations. (Core) am must ensure manageable patient

am must include efforts to enhance n the experience of being a physician, nts, providing administrative support, ce and flexibility, and enhancing

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

demonstrate an understanding of their are of patients entrusted to their care, e conditions and safety events. (Core)

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

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement
VI.B.6.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)	6.12.g.	Programs, in partnership with their Sp process for education of fellows and the behavior and a confidential process for 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 fellowship training. Fellows 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 		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 re members of the health care team are a professionalism; they are also skills t nurtured in the context of other aspect Fellows and faculty members are at ri Programs, in partnership with their Sp same responsibility to address well-b competence. Physicians and all members responsibility for the well-being of eac
VI.C.	<i>clinical learning environment models constructive behaviors, and prepares fellows with the skills and attitudes needed to thrive throughout their careers.</i>	[None]	clinical learning environment models prepares fellows with the skills and a their careers.
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program, in Institution, must include:
VI.C.1.a)		6.13.a.	attention to scheduling, work intensity impacts fellow well-being; (Core)
VI.C.1.b)		6.13.b.	evaluating workplace safety data and faculty members; (Core)
VI.C.1.c)	policies and programs that encourage optimal fellow and faculty member well-being; and, (Core)	6.13.c.	policies and programs that encourage well-being; and, (Core)
VI.C.1.c).(1)	Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)	6.13.c.1.	Fellows must be given the opportunity and dental care appointments, includi working hours. (Core)
VI.C.1.d)	education of fellows and faculty members in:	6.13.d.	education of fellows and faculty mem
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 burn disorders, suicidal ideation, or potent 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-so
VI.C.1.e)	providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)	6.13.e.	providing access to confidential, affor counseling, and treatment, including a 24 hours a day, seven days a week. (O

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

ical well-being are critical in the ng, and resilient physician and require I outside of medicine. Well-being oy in medicine while managing their I responsibility to support other e important components of s that must be modeled, learned, and ects of fellowship training.

risk for burnout and depression. Sponsoring Institutions, have the -being as other aspects of resident mbers of the health care team share each other. A positive culture in a ls constructive behaviors, and attitudes needed to thrive throughout

n partnership with the Sponsoring

ity, and work compression that

d addressing the safety of fellows and

ge optimal fellow and faculty member

nity to attend medical, mental health, Iding those scheduled during their

mbers in:

Irnout, depression, and substance use ntial for violence, including means to conditions; (Core)

emselves and how to seek

screening. (Core)

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

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VI.C.2.	There are circumstances in which fellows 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 fellows unable to perform their patient care responsibilities. (Core)	6.14.	There are circumstances in which fell including but not limited to fatigue, ill medical, parental, or caregiver leave. appropriate length of absence for fello care responsibilities. (Core)
VI.C.2.a)	The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)	6.14.a.	The program must have policies and proverage of patient care and ensure c
VI.C.2.b)	These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. (Core)	6.14.b.	These policies must be implemented v consequences for the fellow who is or work. (Core)
VI.D.	Fatigue Mitigation	6.15.	Fatigue Mitigation Programs must educate all fellows an the signs of fatigue and sleep depriva fatigue mitigation processes. (Detail)
VI.D.1.	Programs must educate all fellows 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 fellows an the signs of fatigue and sleep depriva fatigue mitigation processes. (Detail)
VI.D.2.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)	6.16.	The program, in partnership with its S adequate sleep facilities and safe tran may be too fatigued to safely return h
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
VI.E.1.	Clinical Responsibilities The clinical responsibilities for each fellow must be based on PGY level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. (Core)	6.17.	Clinical Responsibilities The clinical responsibilities for each f patient safety, fellow ability, severity a illness/condition, and available suppo
VI.E.2.	Teamwork Fellows must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the subspecialty and larger health system. (Core)	6.18.	Teamwork Fellows must care for patients in an e communication and promotes safe, in the subspecialty and larger health sys
VI.E.2.a)	The program must provide educational experiences that allow fellows to interact with and learn from other health care professionals, such as physicians in other specialties, advanced practice providers, nurses, social workers, physical therapists, case managers, language interpreters, and dieticians, to achieve effective, interdisciplinary, and interprofessional team-based care. (Core)	6.18.a.	The program must provide educational e with and learn from other health care pro specialties, advanced practice providers, therapists, case managers, language into effective, interdisciplinary, and interprofe
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 hand continuity of care and patient safety. (

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

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

d without fear of negative or was unable to provide the clinical

and faculty members in recognition of /ation, alertness management, and |)

and faculty members in recognition of vation, alertness management, and)

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

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

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

l experiences that allow fellows to interact professionals, such as physicians in other rs, nurses, social workers, physical nterpreters, and dieticians, to achieve ofessional team-based care. (Core)

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

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

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

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Requirement Number		Requirement Number	
VI.E.3.c)	Programs must ensure that fellows are competent in communicating with team members in the hand-off process. (Outcome)	6.19.b.	Programs must ensure that fellows ar team members in the hand-off proces
,	Clinical Experience and Education		•
			Clinical Experience and Education
	Programs, in partnership with their Sponsoring Institutions, must design		Programs, in partnership with their Sp
	an effective program structure that is configured to provide fellows with		an effective program structure that is
L	educational and clinical experience opportunities, as well as reasonable		educational and clinical experience of
VI.F.	opportunities for rest and personal activities.	[None]	opportunities for rest and personal ac
	Maximum Hours of Clinical and Educational Work per Week		
	Clinical and educational work hours must be limited to no more than 80		Maximum Hours of Clinical and Educa Clinical and educational work hours n
	hours per week, averaged over a four-week period, inclusive of all in-		hours per week, averaged over a four-
	house clinical and educational activities, clinical work done from home,		house clinical and educational activiti
VI.F.1.	and all moonlighting. (Core)	6.20.	and all moonlighting. (Core)
			Mandatory Time Free of Clinical Work
			Fellows should have eight hours off b
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	education periods. (Detail)
			Mandatory Time Free of Clinical Work
	Fellows should have eight hours off between scheduled clinical work and		Fellows should have eight hours off b
VI.F.2.a)	education periods. (Detail)	6.21.	education periods. (Detail)
	Fellows must have at least 14 hours free of clinical work and education	0.04	Fellows must have at least 14 hours fu
VI.F.2.b)	after 24 hours of in-house call. (Core)	6.21.a.	after 24 hours of in-house call. (Core)
	Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-		Fellows must be scheduled for a minit clinical work and required education (
VI.F.2.c)	home call cannot be assigned on these free days. (Core)	6.21.b.	home call cannot be assigned on thes
			Maximum Clinical Work and Education
			Clinical and educational work periods
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	hours of continuous scheduled clinica
			Maximum Clinical Work and Education
	Clinical and educational work periods for fellows must not exceed 24		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
	fellow education. Additional patient care responsibilities must not be	C 22 A	fellow education. Additional patient ca
VI.F.3.a).(1)	assigned to a fellow during this time. (Core)	6.22.a.	assigned to a fellow during this time.
			Clinical and Educational Work Hour E
			In rare circumstances, after handing c
			on their own initiative, may elect to re
			the following circumstances: to contin severely ill or unstable patient; to give
			of a patient or patient's family; or to a
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	(Detail)

ent Language
are competent in communicating with ess. (Outcome)
Sponsoring Institutions, must design is configured to provide fellows with opportunities, as well as reasonable activities.
icational Work per Week s must be limited to no more than 80 ur-week period, inclusive of all in- vities, clinical work done from home,
rk and Education f between scheduled clinical work and
rk and Education f between scheduled clinical work and
s free of clinical work and education e)
nimum of one day in seven free of n (when averaged over four weeks). At- ese free days. (Core)
ion Period Length ds for fellows must not exceed 24 ical assignments. (Core)
ion Period Length ds for fellows must not exceed 24 ical assignments. (Core)
may be used for activities related to fective transitions of care, and/or care responsibilities must not be e. (Core)
Exceptions g off all other responsibilities, a fellow, remain or return to the clinical site in atinue to provide care to a single

ive humanistic attention to the needs attend unique educational events.

r Requirement Language	Reformatted Requirement Number	Requirement
In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)	6.23.	Clinical and Educational Work Hour E In rare circumstances, after handing c on their own initiative, may elect to re the following circumstances: to contin severely ill or unstable patient; to give of a patient or patient's family; or to a (Detail)
These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)	6.23.a.	These additional hours of care or edu 80-hour weekly limit. (Detail)
A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.		A Review Committee may grant rotation percent or a maximum of 88 clinical an individual programs based on a sound
The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the fellows' work week.	6.24.	The Review Committee for Internal Medi exceptions to the 80-hour limit to the fello
Moonlighting	6.25.	Moonlighting Moonlighting must not interfere with t goals and objectives of the education with the fellow's fitness for work nor o
goals and objectives of the educational program, and must not interfere		Moonlighting Moonlighting must not interfere with t goals and objectives of the education with the fellow's fitness for work nor o
Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)	6.25.a.	Time spent by fellows in internal and the ACGME Glossary of Terms) must maximum weekly limit. (Core)
In-House Night Float Night float must occur within the context of the 80-hour and one-day-off-in- seven requirements. (Core)		In-House Night Float Night float must occur within the cont seven requirements. (Core)
Maximum In-House On-Call Frequency Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)	6.27.	Maximum In-House On-Call Frequency Fellows must be scheduled for in-hou every third night (when averaged over
At-Home Call	6.28.	At-Home Call Time spent on patient care activities b count toward the 80-hour maximum w home call is not subject to the every-t the requirement for one day in seven t when averaged over four weeks. (Core
the requirement for one day in seven free of clinical work and education,		At-Home Call Time spent on patient care activities to count toward the 80-hour maximum w home call is not subject to the every-t the requirement for one day in seven when averaged over four weeks. (Core
	on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail) These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the fellows' work week. Moonlighting Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety. (Core) Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core) In-House Night Float Night float must occur within the context of the 80-hour and one-day-off-in- seven requirements. (Core) Maximum In-House On-Call Frequency Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core) At-Home Call Time spent on patient care activities by fellows 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,	Requirement Language Requirement Number In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient; to give humanistic attention to the needs of a patient or patient; to give humanistic attention to the needs of a patient or patient; to give humanistic attention to the needs of a patient or patient; to give humanistic attention to the needs of a patient or patient; to give humanistic attention to the needs of a patient or patient; to give humanistic attention to the needs of a patient or patient; to give humanistic attention to the needs of a patient or patient; to give humanistic attention to the needs of a patient or patient; to give humanistic attention to the needs of a patient or patient; and the device attention to the needs of a patient or patient; and the device attention at the second individual programs based on a sound educational work hours to individual programs based on a sound educational attentionale. 6.23. The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the fellows' work week. 6.24. Moonlighting 6.25. Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the follow's fitness for work nor compromise patient safety. (Core) 6.25. Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core

Exceptions g off all other responsibilities, a fellow, remain or return to the clinical site in tinue to provide care to a single ive humanistic attention to the needs attend unique educational events.

lucation must be counted toward the

tion-specific exceptions for up to 10 and educational work hours to nd educational rationale.

dicine will not consider requests for ellows' work week.

n the ability of the fellow to achieve the onal program, and must not interfere r compromise patient safety. (Core)

n the ability of the fellow to achieve the onal program, and must not interfere r compromise patient safety. (Core)

d external moonlighting (as defined in t be counted toward the 80-hour

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

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

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

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Requirement Number	Requirement Language	Requirement Number	Requirement
	At-home call must not be so frequent or taxing as to preclude rest or		At-home call must not be so frequent
VI.F.8.a).(1)	reasonable personal time for each fellow. (Core)	6.28.a.	reasonable personal time for each fell

ent Language nt or taxing as to preclude rest or fellow. (Core)