Requirement		Reformatted	
Number - Roman Numerals	Requirement Language	Requirement Number	Requirement
	Definition of Graduate Medical Education Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many		Definition of Graduate Medical Educat Graduate medical education is the cru development between medical school is in this vital phase of the continuum learn to provide optimal patient care u members who not only instruct, but s compassion, cultural sensitivity, profe Graduate medical education transform scholars who care for the patient, pati community; create and integrate new educate future generations of physici patterns established during graduate
Int.A.	years later.	[None]	years later.
	Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.		Graduate medical education has as a responsibility for patient care. The can appropriate faculty supervision and co residents to attain the knowledge, skin empathy required for autonomous pra- develops physicians who focus on ex equitable, affordable, quality care; and serve. Graduate medical education va group of physicians brings to medical inclusive and psychologically safe lead
	Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well- being of patients, residents, fellows, faculty members, students, and all		Graduate medical education occurs in foundation for practice-based and life development of the physician, begun through faculty modeling of the efface environment that emphasizes joy in co rigor, and discovery. This transformat and intellectually demanding and occu environments committed to graduate being of patients, residents, fellows, f
Int.A. (Continued)	members of the health care team.	[None] - (Continued)	members of the health care team.
Int.B.	Definition of Specialty Otolaryngologists provide comprehensive medical and surgical care to patients with diseases and disorders that affect the ears, the respiratory and upper alimentary systems, and related structures of the head and neck.	[None]	Definition of Specialty Otolaryngologists provide comprehensive with diseases and disorders that affect the alimentary systems, and related structure

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

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

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

in clinical settings that establish the ifelong learning. The professional in in medical school, continues in event of self-interest in a humanistic curiosity, problem-solving, academic nation is often physically, emotionally, ccurs in a variety of clinical learning the medical education and the well-, faculty members, students, and all

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

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requirement
Int.C.	Length of Educational Program The educational program in otolaryngology – head and neck surgery must be 60 months in length. (Core)	4.1.	Length of Educational Program The educational program in otolaryngolo months in length. (Core)
I.	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 Requirements.
I.A.	When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.	[None]	When the Sponsoring Institution is no most commonly utilized site of clinica primary clinical site.
I.A.1.	The program must be sponsored by one ACGME-accredited Sponsoring Institution.	1.1.	The program must be sponsored by o Institution.
I.B.	Participating Sites A participating site is an organization providing educational experiences or educational assignments/rotations for residents.	[None]	Participating Sites A participating site is an organization or educational assignments/rotations
I.B.1.	The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)	1.2.	The program, with approval of its Spo primary clinical site. (Core)
I.B.2. I.B.2.a)	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) The PLA must:	1.3. [None]	There must be a program letter of agro and each participating site that govern program and the participating site pro
I.B.2.a).(1)	be renewed at least every 10 years; and, (Core)	1.3.a.	The PLA must be renewed at least eve
I.B.2.a).(2)	be approved by the designated institutional official (DIO). (Core)	1.3.b.	The PLA must be approved by the des (Core)
I.B.3.	The program must monitor the clinical learning and working environment at all participating sites. (Core)	1.4.	The program must monitor the clinica at all participating sites. (Core)
I.B.3.a).	At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)	1.5.	At each participating site there must by by the program director as the site dir resident education at that site, in colla (Core)
I.B.4.	The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)	1.6.	The program director must submit any participating sites routinely providing for all residents, of one month full tim the ACGME's Accreditation Data Syste
I.B.5.	The addition of any participating site must be approved by the Review Committee prior to assigning any residents to that site. (Core)	1.6.a.	The addition of any participating site mus Committee prior to assigning any resider

logy – head and neck surgery must be 60

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

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

one ACGME-accredited Sponsoring

on providing educational experiences ns for residents.

oonsoring Institution, must designate a

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

every 10 years. ^(Core) lesignated institutional official (DIO).

cal learning and working environment

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

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

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

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requirement
	Workforce Recruitment and Retention The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if		Workforce Recruitment and Retention The program, in partnership with its S in practices that focus on mission-driv and retention of a diverse and inclusiv
	present), faculty members, senior administrative GME staff members, and		present), faculty members, senior adn
I.C.	other relevant members of its academic community. (Core)	1.7.	other relevant members of its academ
	Pasauraaa	1.8.	Resources The program, in partnership with its S the availability of adequate resources
I.D.	Resources	1.0.	
I.D.1.	The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)	1.8.	Resources The program, in partnership with its S the availability of adequate resources
I.D.1.a)	There must be space and equipment for the educational program, including 24- hour computer access with Internet, classrooms with audiovisual and other educational aids, meeting rooms, and office space for residents. (Core)	1.8.a.	There must be space and equipment for hour computer access with Internet, clas educational aids, meeting rooms, and off
I.D.1.b)	There must be current information technology readily available for clinical care. (Core)	1.8.b.	There must be current information technol (Core)
I.D.1.c)	Each participating site must provide beds and operating time sufficient for the needs of the service and for resident education. (Core)	1.8.c.	Each participating site must provide beds needs of the service and for resident edu
I.D.1.d)	Residents must have access to outpatient facilities that provide clinics and office space for education in the regular pre-operative evaluation and postoperative follow-up of cases for which each resident has responsibility. (Core)	1.8.d.	Residents must have access to outpatier office space for education in the regular postoperative follow-up of cases for whic (Core)
, I.D.1.e)	Technologically current equipment considered necessary for diagnosis and treatment must be available. (Core)	1.8.e.	Technologically current equipment considered treatment must be available. (Core)
I.D.1.f)	There should be clinical services in the related fields of anesthesiology, emergency medicine, internal medicine, neurological surgery, neurology, ophthalmology, pathology, pediatrics, and radiology. (Core)	1.8.f.	There should be clinical services in the re emergency medicine, internal medicine, ophthalmology, pathology, pediatrics, an
I.D.1.g)	There must be a variety of adult and pediatric medical and surgical patients available to allow development of resident competency in patient care. (Core)	1.8.g.	There must be a variety of adult and ped available to allow development of resider
I.D.2.	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:	1.9.	The program, in partnership with its S healthy and safe learning and working resident well-being and provide for:
I.D.2.a)	access to food while on duty; (Core)	1.9.a.	access to food while on duty; (Core)
I.D.2.b)	safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)	1.9.b.	safe, quiet, clean, and private sleep/re for residents with proximity appropria
I.D.2.c)	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	clean and private facilities for lactation with proximity appropriate for safe pa
I.D.2.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures appropr (Core)

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

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

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

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

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

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

sidered necessary for diagnosis and

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

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

Sponsoring Institution, must ensure ng environments that promote

rest facilities available and accessible iate for safe patient care; (Core) ion that have refrigeration capabilities, patient care; (Core)

priate to the participating site; and,

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
	accommodations for residents with disabilities consistent with the		accommodations for residents with d
I.D.2.e)	Sponsoring Institution's policy. (Core)	1.9.e.	Sponsoring Institution's policy. (Core
I.D.3.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)	1.10.	Residents must have ready access to appropriate reference material in prin include access to electronic medical capabilities. (Core)
I.E.	Other Learners and Health Care Personnel The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)	1.11.	Other Learners and Health Care Person The presence of other learners and of but not limited to residents from othe and advanced practice providers, mu appointed residents' education. (Core
II.	Personnel	Section 2	Section 2: Personnel
II.A.	Program Director	2.1.	Program Director There must be one faculty member ap 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 or with all applicable program requireme
II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)	2.2.	The Sponsoring Institution's GMEC m director and must verify the program appointment. (Core)
	Final approval of the program director resides with the Review Committee. (Core)	2.2.a.	Final approval of the program directo (Core)
II.A.1.a).(1) II.A.1.b)	The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)	2.3.	The program must demonstrate reten length of time adequate to maintain c stability. (Core)
II.A.2.	The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)	2.4.	The program director and, as 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) Number of Approved Resident Positions: 1-10 Minimum Support Required (FTE): 10% Number of Approved Resident Positions: 11 or more Minimum Support		At a minimum, the program director mus and support specified below for administ Number of Approved Resident Positions (FTE): 10% Number of Approved Resident Positions
II.A.2.a) II.A.3 .	Required (FTE): 20% Qualifications of the program director:	2.4.a. 2.5.	Required (FTE): 20% Qualifications of the Program Directo The program director must possess s years of documented educational and qualifications acceptable to the Revie

disabilities consistent with the re)

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

rsonnel

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

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

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

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

tor resides with the Review Committee.

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

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

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

ns: 1-10 | Minimum Support Required

ns: 11 or more | Minimum Support

tor

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

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requirement
II.A.3.a)	must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)	2.5.	Qualifications of the Program Directo The program director must possess s years of documented educational and qualifications acceptable to the Revie
II.A.3.b)	must include current certification in the specialty for which they are the program director by the American Board of Otolaryngology – Head and Neck Surgery (ABOHNS), or by the American Osteopathic Board of Ophthalmology and Otolaryngology – Head and Neck Surgery (AOBOO-HNS), or specialty qualifications that are acceptable to the Review Committee; (Core)	2.5.a.	The program director must possess c for which they are the program director Otolaryngology – Head and Neck Surger Osteopathic Board of Ophthalmology a Surgery (AOBOO-HNS), or specialty qu the Review Committee. (Core)
II.A.3.b).(1)	The Review Committee accepts only ABOHNS or AOBOO-HNS certification. (Core)	2.5.a.1.	The Review Committee accepts only AB (Core)
II.A.3.c)	must include ongoing clinical activity. (Core)	2.5.b.	The program director must demonstra
II.A.3.d)	must include evidence of periodic updates of knowledge and skills to discharge the roles and responsibilities for teaching, supervision, and formal evaluation of residents. (Core)	2.5.c.	The program director must demonstrate knowledge and skills to discharge the ro supervision, and formal evaluation of res
II.A.4.	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)	2.6.	Program Director Responsibilities The program director must have resp accountability for: administration and activity; resident recruitment and sele residents, and disciplinary action; su education in the context of patient car
II.A.4.a)		[None]	
II.A.4.a).(1)	be a role model of professionalism; (Core)	2.6.a.	The program director must be a role r
II.A.4.a).(2)	design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)	2.6.b.	The program director must design an consistent with the needs of the com Sponsoring Institution, and the mission
II.A.4.a).(3)	administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)	2.6.c.	The program director must administe environment conducive to educating Competency domains. (Core)
II.A.4.a).(4)	have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)	2.6.d.	The program director must have the a physicians and non-physicians as fac sites, including the designation of con develop and oversee a process to eva (Core)
II.A.4.a).(5)	have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)	2.6.e.	The program director must have the 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	2.6.f.	The program director must submit ac required and requested by the DIO, G

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

ctor by the American Board of pery (ABOHNS), or by the American and Otolaryngology – Head and Neck qualifications that are acceptable to

BOHNS or AOBOO-HNS certification.

trate ongoing clinical activity. (Core)

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

ponsibility, authority, and

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

model of professionalism. (Core)

and conduct the program in a fashion mmunity, the mission(s) of the sion(s) of the program. (Core)

ter and maintain a learning g the residents in each of the ACGME

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

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

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

Otolaryngology - Head and Neck Surgery Crosswalk

Requirement		Reformatted	
Number - Roman Numerals	Requirement Language	Requirement Number	Requiremen
II.A.4.a).(7)	provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)	2.6.g.	The program director must provide a which residents have the opportunity mistreatment, and provide feedback i appropriate, without fear of intimidati
II.A.4.a).(8)	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; (Core)	2.6.h.	The program director must ensure th Sponsoring Institution's policies and and due process, including when act not to promote or renew the appointm
II.A.4.a).(9)	ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)	2.6.i.	The program director must ensure the Sponsoring Institution's policies and discrimination. (Core)
II.A.4.a).(9).(a)	Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Residents must not be required to sig
II.A.4.a).(10)	document verification of education for all residents within 30 days of completion of or departure from the program; and, (Core)	2.6.j.	The program director must document residents within 30 days of completion (Core)
II.A.4.a).(11)	provide verification of an individual resident's education upon the resident's request, within 30 days; and (Core)	2.6.k.	The program director must provide ve education upon the resident's reques
II.A.4.a).(12)	provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)	2.6.1.	The program director must provide a interview with information related to t relevant specialty board examination
	Faculty Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.		Faculty Faculty members are a foundational of education – faculty members teach re Faculty members provide an importa and become practice-ready, ensuring quality of care. They are role models by demonstrating compassion, comm patient care, professionalism, and a of Faculty members experience the priod development of future colleagues. The the opportunity to teach and model ef scholarly approach to patient care, fa graduate medical education system, and and the population.
П.В.	Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.	[None]	Faculty members ensure that patient from a specialist in the field. They rea the patients, residents, community, a provide appropriate levels of supervi Faculty members create an effective professional manner and attending to themselves.

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

the program's compliance with the nd procedures related to grievances ction is taken to suspend or dismiss, or atment of a resident. (Core) the program's compliance with the nd procedures on employment and non-

sign a non-competition guarantee or

ent verification of education for all tion of or departure from the program.

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

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

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

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

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requirement Language
II.B.1.	There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)	2.7.	There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)
II.B.1.a)	In addition to the program director, there should be at least two other FTE faculty members with qualifications to include: (Core)	2.7.a.	In addition to the program director, there should be at least two other FTE faculty members with qualifications to include: (Core)
II.B.1.a).(1)	specialty expertise and documented educational and administrative experience	2.7.a.1.	specialty expertise and documented educational and administrative experience acceptable to the Review Committee; and, (Core)
II.B.1.a).(2)		2.7.a.2.	appropriate medical staff appointment. (Core)
II.B.2.	Faculty members must:	[None]	
		[]	Faculty Responsibilities
II.B.2.a)	be role models of professionalism; (Core)	2.8.	Faculty members must be role models of professionalism. (Core)
II.B.2.b)	demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)	2.8.a.	Faculty members must demonstrate commitment to the delivery of safe,
п.д.2.0)	cost-enective, patient-centered care; (Core)	2.0.d.	equitable, high-quality, cost-effective, patient-centered care. (Core)
	demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their		Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to
II.B.2.c)	supervisory and teaching responsibilities; (Core)	2.8.b.	fulfill their supervisory and teaching responsibilities. (Core)
	administer and maintain an educational environment conducive to		Faculty members must administer and maintain an educational
II.B.2.d)	educating residents; (Core)	2.8.c.	environment conducive to educating residents. (Core)
	regularly participate in organized clinical discussions, rounds, journal		Faculty members must regularly participate in organized clinical
II.B.2.e)	clubs, and conferences; and, (Core)	2.8.d.	discussions, rounds, journal clubs, and conferences. (Core)
	pursue faculty development designed to enhance their skills at least		Faculty members must pursue faculty development designed to enhance
II.B.2.f)	annually: (Core)	2.8.e.	their skills at least annually: (Core)
II.B.2.f).(1)	as educators and evaluators; (Detail)	2.8.e.1.	as educators and evaluators; (Detail)
II.B.2.f).(2)	in quality improvement, eliminating health inequities, and patient safety; (Detail)	2.8.e.2.	in quality improvement, eliminating health inequities, and patient safety; (Detail)
II.B.2.f).(3)	in fostering their own and their residents' well-being; and, (Detail)	2.8.e.3.	in fostering their own and their residents' well-being; and, (Detail)
II.B.2.f).(4)	in patient care based on their practice-based learning and improvement efforts. (Detail)	2.8.e.4.	in patient care based on their practice-based learning and improvement efforts. (Detail)
II.B.2.f).(5)	A faculty member serving as a local site director must have major clinical responsibilities at that site. (Core)	2.8.f.	A faculty member serving as a local site director must have major clinical responsibilities at that site. (Core)
II.B.3.	Faculty Qualifications	2.9.	Faculty Qualifications Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)
II.B.3.a)	Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)	2.9.	Faculty Qualifications Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)
II.B.3.b)		[None]	
II.B.3.b).(1)	have current certification in the specialty by the American Board of Otolaryngology – Head and Neck Surgery or the American Osteopathic Board of Ophthalmology and Otolaryngology – Head and Neck Surgery, or possess qualifications judged acceptable to the Review Committee. (Core)		Physician faculty members must have current certification in the specialty by the American Board of Otolaryngology – Head and Neck Surgery or the American Osteopathic Board of Ophthalmology and Otolaryngology – Head and Neck Surgery, or possess qualifications judged acceptable to the Review Committee. (Core)

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requirement
	Core Faculty		
II.B.4.	Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)	2.11.	Core Faculty Core faculty members must have a sign supervision of residents and must de- entire effort to resident education and component of their activities, teach, e feedback to residents. (Core)
	Core faculty members must complete the annual ACGME Faculty Survey.		Core faculty members must complete
II.B.4.a)	(Core)	2.11.a.	(Core)
II.B.4.b)	There must be at least five core faculty members who are ABOHNS or AOBOO- HNS certified in otolaryngology – head and neck surgery. (Core)	2.11.b.	There must be at least five core faculty n HNS certified in otolaryngology – head a
II.C.	Program Coordinator	2.12.	Program Coordinator There must be a program coordinator
			Program Coordinator
II.C.1.	There must be a program coordinator. (Core)	2.12.	There must be a program coordinator
II.C.2.	The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)	2.12.a.	The program coordinator must be pro support adequate for administration of and configuration. (Core)
II.C.2.a)	At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core) Number of Approved Resident Positions: 1-10 Minimum FTE: 50% Number of Approved Resident Positions: 11 or more Minimum FTE: 80%	2.12.b.	At a minimum, the program coordinator r time and support specified below for adm Number of Approved Resident Positions Number of Approved Resident Positions
II.D.	Other Program Personnel The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)	2.13.	Other Program Personnel The program, in partnership with its S ensure the availability of necessary pe administration of the program. (Core)
II.D.1. III.	This must include speech pathologists, audiologists, and/or balance therapists necessary for carrying out audiologic and vestibular testing and rehabilitation. (Core) Resident Appointments	2.13.a. Section 3	This must include speech pathologists, a necessary for carrying out audiologic and (Core) Section 3: Resident Appointments
····			Eligibility Requirements
II.A.	Eligibility Requirements	3.2.	An applicant must meet one of the fol for appointment to an ACGME-accred
III.A.1.	An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)	3.2.	Eligibility Requirements An applicant must meet one of the fol for appointment to an ACGME-accred
	graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College		graduation from a medical school in the Liaison Committee on Medical Educate college of osteopathic medicine in the American Osteopathic Association Co
III.A.1.a)	Accreditation (AOACOCA); or, (Core)	3.2.a.	Accreditation (AOACOCA); or, (Core)

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

te the annual ACGME Faculty Survey.

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

or. (Core)

or. (Core)

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

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

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

Sponsoring Institution, must jointly personnel for the effective

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

ollowing qualifications to be eligible edited program: (Core)

ollowing qualifications to be eligible edited program: (Core)

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

Requirement		Reformatted	
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Numerals	Requirement Language	Number	Requirement Language
			 graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)
	graduation from a medical school outside of the United States, and		• holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is
III.A.1.b)	meeting one of the following additional qualifications: (Core)	3.2.b.	located. (Core)
			graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)
III.A.1.b).(1)	holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)	3.2.b.	 holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)
			graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)
III.A.1.b).(2)	holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)	3.2.b.	• holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)
	All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)- accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty		All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)- accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation (Coro)
III.A.2.	Accreditation. (Core)	3.3.	Accreditation. (Core)
III.A.2.a)	Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)	3.3.a.	Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)
	Resident Complement		
	The program director must not appoint more residents than approved by		Resident Complement The program director must not appoint more residents than approved by
III.B.	the Review Committee. (Core)	3.4.	the Review Committee. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
III.B.1.	If a vacancy in a program's resident complement is filled, it should be filled at the same level in which it occurs. Exceptions must be approved by the Review Committee. (Core)	3.4.a.	If a vacancy in a program's resident con the same level in which it occurs. Excep Committee. (Core)
	Resident Transfers	-	
III.C.	The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)	3.5.	Resident Transfers The program must obtain verification and a summative competency-based acceptance of a transferring resident matriculation. (Core)
III.C.1.	The Review Committee for Otolaryngology – Head and Neck Surgery does not allow transfer into an ACGME-accredited otolaryngology – head and neck surgery program at the PGY-2 level or above from a RCPSC-accredited program. (Core)	3.5.a.	The Review Committee for Otolaryngolo allow transfer into an ACGME-accredited surgery program at the PGY-2 level or a program. (Core)
	Educational Program The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.		Section 4: Educational Program The ACGME accreditation system is o and innovation in graduate medical e organizational affiliation, size, or loca
	The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care. It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will		The educational program must support knowledgeable, skillful physicians whe It is recognized programs may place leadership, public health, etc. It is exp
IV.	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	reflect the nuanced program-specific example, it is expected that a program scientists will have a different curricu community health.
	Educational Components		Educational Components
IV.A. IV.A.1.	The curriculum must contain the following educational components: a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)	4.2. 4.2.a.	The curriculum must contain the follo a set of program aims consistent with mission, the needs of the community capabilities of its graduates, which m applicants, residents, and faculty me
IV.A.2.	competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)	4.2.b.	competency-based goals and objectiv designed to promote progress on a tr These must be distributed, reviewed, faculty members; (Core)
IV.A.3.	delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)	4.2.c.	delineation of resident responsibilitie responsibility for patient managemen
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured didactic a

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

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

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

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

port the development of who provide compassionate care.

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

llowing educational components:

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

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

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

Requirement		Reformatted	
Number - Roman		Requirement	
Numerals	Requirement Language	Number	Requirement
			Curriculum Organization and Residen
			Experiences
	Residents must be provided with protected time to participate in core		Residents must be provided with prot
IV.A.4.a)	didactic activities. (Core)	4.11.	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 pror tools, and techniques. (Core)
		7.2.0.	
			ACGME Competencies
			The Competencies provide a concept
			required domains for a trusted physic
			These Competencies are core to the p
			the specifics are further defined by ea
			trajectories in each of the Competenc
IV.B.	ACGME Competencies	[None]	Milestones for each specialty.
IV.B.1.	The program must integrate the following ACGME Competencies into the curriculum:	[None]	The program must integrate all ACGM
			ACGME Competencies – Professional
	Professionalism		Residents must demonstrate a commi
			adherence to ethical principles. (Core
	Residents must demonstrate a commitment to professionalism and an		
IV.B.1.a)	adherence to ethical principles. (Core)	4.3.	Residents must demonstrate compete
			ACGME Competencies – Professional
			Residents must demonstrate a commi
			adherence to ethical principles. (Core
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	Residents must demonstrate compete
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)	4.3.a.	compassion, integrity, and respect for
$IV = 1 + 2 \cdot (1) + (1)$	responsiveness to nation people that supercedes calf interact. (Core)	4.3.b.	reasonativeness to nationt people that
IV.B.1.a).(1).(b) IV.B.1.a).(1).(c)	responsiveness to patient needs that supersedes self-interest; (Core) cultural humility; (Core)	4.3.c.	responsiveness to patient needs that cultural humility; (Core)
IV.B.1.a).(1).(d)	respect for patient privacy and autonomy; (Core)	4.3.d.	respect for patient privacy and autono
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)	4.3.e.	accountability to patients, society, and
	respect and responsiveness to diverse patient populations, including but		respect and responsiveness to divers
	not limited to diversity in gender, age, culture, race, religion, disabilities,		not limited to diversity in gender, age,
IV.B.1.a).(1).(f)	national origin, socioeconomic status, and sexual orientation; (Core)	4.3.f.	national origin, socioeconomic status
	ability to recognize and develop a plan for one's own personal and		ability to recognize and develop a pla
IV.B.1.a).(1).(g)	professional well-being; and, (Core)	4.3.g.	professional well-being; and, (Core)
	appropriately disclosing and addressing conflict or duality of interest.		appropriately disclosing and addressi
IV.B.1.a).(1).(h)	(Core)	4.3.h.	(Core)
IV.B.1.b)	Patient Care and Procedural Skills	[None]	
			ACGME Competencies – Patient Care
	Residents must be able to provide patient care that is patient- and family-		Residents must be able to provide pat
	centered, compassionate, equitable, appropriate, and effective for the		centered, compassionate, equitable, a
IV.B.1.b).(1)	treatment of health problems and the promotion of health. (Core)	4.4.	treatment of health problems and the
IV.B.1.b).(1).(a)	Residents must demonstrate competence in care that is: (Core)	[None]	· ·

ent Experiences – Didactic and Clinical

otected time to participate in core

omote patient safety-related goals,

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

ME Competencies into the curriculum.

alism mitment to professionalism and an re)

etence in:

alism mitment to professionalism and an re)

etence in: for others; (Core)

at supersedes self-interest; (Core)

nomy; (Core) and the profession; (Core)

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

ssing conflict or duality of interest.

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

Otolaryngology - Head and Neck Surgery Crosswalk

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
			Residents must demonstrate competen
IV.B.1.b).(1).(a).(i)	culturally sensitive; (Core)	4.4.a.	(Core)
IV.B.1.b).(1).(a).(ii)	situationally sensitive; and, (Core)	4.4.b.	Residents must demonstrate competene (Core)
			Residents must demonstrate competend
IV.B.1.b).(1).(a).(iii)	specific to the particular patient's/family's needs. (Core)	4.4.c.	patient's/family's needs. (Core)
$1 \setminus D = 1 = b \setminus (1) = (b)$	Residents must demonstrate competence in formulating differential diagnoses	4.4.d.	Residents must demonstrate competend
IV.B.1.b).(1).(b)	of conditions affecting the head and neck; (Core)	4.4.u.	of conditions affecting the head and nec Residents must demonstrate competence
IV.B.1.b).(1).(c)	Residents must demonstrate competence in care that is accurate in diagnosis and treatment care options. (Core)	4.4.e.	and treatment care options. (Core)
TV.D.T.D).(T).(C)		4.4.6.	
IV.B.1.b).(1).(d)	Residents must demonstrate competence in interpreting data and developing patient care plans for the following diagnostic procedures: (Core)	4.4.f.	Residents must demonstrate competend patient care plans for the following diagr
IV.B.1.b).(1).(d).(i)	audiology testing; (Core)	4.4.f.1.	audiology testing; (Core)
IV.B.1.b).(1).(d).(ii)	histopathology studies; (Core)	4.4.f.2.	histopathology studies; (Core)
IV.B.1.b).(1).(d).(iii)	imaging studies of the head and neck; (Core)	4.4.f.3.	imaging studies of the head and neck; (
IV.B.1.b).(1).(d).(iv)	laboratory testing; (Core)	4.4.f.4.	laboratory testing; (Core)
IV.B.1.b).(1).(d).(v)	sleep studies; (Core)	4.4.f.5.	sleep studies; (Core)
IV.B.1.b).(1).(d).(vi)	speech and voice testing; and, (Core)	4.4.f.6.	speech and voice testing; and, (Core)
IV.B.1.b).(1).(d).(vii)	vestibular testing. (Core)	4.4.f.7.	vestibular testing. (Core)
	Residents must be able to perform all medical, diagnostic, and surgical		ACGME Competencies – Procedural perform all medical, diagnostic, and s
IV.B.1.b).(2)	procedures considered essential for the area of practice. (Core)	4.5.	essential for the area of practice. (Co
IV.B.1.b).(2).(a)	Residents must demonstrate competence in performing and interpreting the		Residents must demonstrate competence
	I data regulting trap the tellowing diagnastic procedures, (Care)	1 5 6	data regulting from the following diagno
	data resulting from the following diagnostic procedures: (Core)	4.5.a.	data resulting from the following diagnos
IV.B.1.b).(2).(a).(i)	allergy testing; (Core)	4.5.a.1.	allergy testing; (Core)
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii)	allergy testing; (Core) clinical history and exam; (Core)	4.5.a.1. 4.5.a.2.	allergy testing; (Core) clinical history and exam; (Core)
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core)	4.5.a.1. 4.5.a.2. 4.5.a.3.	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core)
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core)	4.5.a.1. 4.5.a.2.	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core)
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative)	4.5.a.1. 4.5.a.2. 4.5.a.3.	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii) IV.B.1.b).(2).(a).(iv)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head	4.5.a.1. 4.5.a.2. 4.5.a.3. 4.5.a.4.	allergy testing; (Core)clinical history and exam; (Core)facial analysis; and, (Core)smell and taste testing. (Core)Residents must demonstrate competend and non-surgical management and treat
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(b)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head and neck, including: (Core)	4.5.a.1. 4.5.a.2. 4.5.a.3. 4.5.a.4. 4.5.b.	allergy testing; (Core)clinical history and exam; (Core)facial analysis; and, (Core)smell and taste testing. (Core)Residents must demonstrate competendand non-surgical management and treatand neck, including: (Core)
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(b) IV.B.1.b).(2).(b)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head and neck, including: (Core) aerodigestive foreign body obstruction; (Core)	4.5.a.1. 4.5.a.2. 4.5.a.3. 4.5.a.4. 4.5.b. 4.5.b.1.	allergy testing; (Core)clinical history and exam; (Core)facial analysis; and, (Core)smell and taste testing. (Core)Residents must demonstrate competendand non-surgical management and treatand neck, including: (Core)aerodigestive foreign body obstruction; (
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(b) IV.B.1.b).(2).(b).(ii)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head and neck, including: (Core) aerodigestive foreign body obstruction; (Core) allergic and immunologic disorders; (Core)	4.5.a.1. 4.5.a.2. 4.5.a.3. 4.5.a.4. 4.5.b. 4.5.b.1. 4.5.b.1. 4.5.b.2.	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competend and non-surgical management and treat and neck, including: (Core) aerodigestive foreign body obstruction; of allergic and immunologic disorders; (Core)
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(b).(ii) IV.B.1.b).(2).(b).(ii) IV.B.1.b).(2).(b).(iii)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head and neck, including: (Core) aerodigestive foreign body obstruction; (Core) allergic and immunologic disorders; (Core) chemoreceptive disorders; (Core)	 4.5.a.1. 4.5.a.2. 4.5.a.3. 4.5.a.4. 4.5.b. 4.5.b.1. 4.5.b.2. 4.5.b.3. 	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competend and non-surgical management and treat and neck, including: (Core) aerodigestive foreign body obstruction; allergic and immunologic disorders; (Core) chemoreceptive disorders; (Core)
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(b).(i) IV.B.1.b).(2).(b).(ii) IV.B.1.b).(2).(b).(iii) IV.B.1.b).(2).(b).(iv)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head and neck, including: (Core) aerodigestive foreign body obstruction; (Core) allergic and immunologic disorders; (Core) chemoreceptive disorders; (Core) voice, speech, and swallowing disorders; (Core)	4.5.a.1. 4.5.a.2. 4.5.a.3. 4.5.a.4. 4.5.b.1. 4.5.b.1. 4.5.b.2. 4.5.b.3. 4.5.b.4.	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competend and non-surgical management and treat and neck, including: (Core) aerodigestive foreign body obstruction; of allergic and immunologic disorders; (Core) voice, speech, and swallowing disorders
IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(b).(i) IV.B.1.b).(2).(b).(ii) IV.B.1.b).(2).(b).(iii) IV.B.1.b).(2).(b).(iv) IV.B.1.b).(2).(b).(iv)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head and neck, including: (Core) aerodigestive foreign body obstruction; (Core) allergic and immunologic disorders; (Core) chemoreceptive disorders; (Core) voice, speech, and swallowing disorders; (Core) disorders related to the geriatric population; (Core)	 4.5.a.1. 4.5.a.2. 4.5.a.3. 4.5.a.4. 4.5.b.1. 4.5.b.2. 4.5.b.3. 4.5.b.4. 4.5.b.5. 	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competend and non-surgical management and treat and neck, including: (Core) aerodigestive foreign body obstruction; allergic and immunologic disorders; (Core) voice, speech, and swallowing disorders disorders related to the geriatric populat
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IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(b).(i) IV.B.1.b).(2).(b).(ii) IV.B.1.b).(2).(b).(iii) IV.B.1.b).(2).(b).(iv) IV.B.1.b).(2).(b).(vi) IV.B.1.b).(2).(b).(vi)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head and neck, including: (Core) aerodigestive foreign body obstruction; (Core) allergic and immunologic disorders; (Core) chemoreceptive disorders; (Core) voice, speech, and swallowing disorders; (Core) disorders related to the geriatric population; (Core) endocrine disorders related to the thyroid and parathyroid; (Core) facial plastic and reconstructive disorders; (Core)	4.5.a.1. 4.5.a.2. 4.5.a.3. 4.5.a.4. 4.5.b.1. 4.5.b.2. 4.5.b.3. 4.5.b.4. 4.5.b.5. 4.5.b.6. 4.5.b.7.	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competend and non-surgical management and treat and neck, including: (Core) aerodigestive foreign body obstruction; (Core) allergic and immunologic disorders; (Core) voice, speech, and swallowing disorders disorders related to the geriatric populat endocrine disorders related to the thyroi
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IV.B.1.b).(2).(a).(i) IV.B.1.b).(2).(a).(ii) IV.B.1.b).(2).(a).(iii) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(a).(iv) IV.B.1.b).(2).(b).(i) IV.B.1.b).(2).(b).(ii) IV.B.1.b).(2).(b).(iii) IV.B.1.b).(2).(b).(iv) IV.B.1.b).(2).(b).(vi) IV.B.1.b).(2).(b).(vi) IV.B.1.b).(2).(b).(vii) IV.B.1.b).(2).(b).(vii) IV.B.1.b).(2).(b).(vii) IV.B.1.b).(2).(b).(vii) IV.B.1.b).(2).(b).(x) IV.B.1.b).(2).(b).(x)	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head and neck, including: (Core) aerodigestive foreign body obstruction; (Core) allergic and immunologic disorders; (Core) voice, speech, and swallowing disorders; (Core) disorders related to the geriatric population; (Core) endocrine disorders related to the thyroid and parathyroid; (Core) facial plastic and reconstructive disorders; (Core) idiopathic disorders (Core) metabolic disorders; (Core) neoplastic disorders; (Core) neurologic disorders related to the head and neck; (Core)	 4.5.a.1. 4.5.a.2. 4.5.a.3. 4.5.a.4. 4.5.b.1. 4.5.b.2. 4.5.b.3. 4.5.b.4. 4.5.b.5. 4.5.b.6. 4.5.b.7. 4.5.b.8. 4.5.b.9. 4.5.b.10. 4.5.b.11. 4.5.b.12. 	allergy testing; (Core) clinical history and exam; (Core) facial analysis; and, (Core) smell and taste testing. (Core) Residents must demonstrate competence and non-surgical management and treat and neck, including: (Core) aerodigestive foreign body obstruction; of allergic and immunologic disorders; (Core) voice, speech, and swallowing disorders disorders related to the geriatric populat endocrine disorders related to the thyroi facial plastic and reconstructive disorders; (Core) infectious and inflammatory disorders; (Core) neoplastic disorders; (Core) neoplastic disorders; (Core) neurologic disorders; related to the head

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ence in care that is culturally sensitive.

ence in care that is situationally sensitive.

ence in care that is specific to the particular

ence in formulating differential diagnoses leck. (Core)

ence in care that is accurate in diagnosis

ence in interpreting data and developing agnostic procedures: (Core)

(Core)

al Skills: Residents must be able to d surgical procedures considered Core)

ence in performing and interpreting the nostic procedures: (Core)

ence in surgical (including peri-operative) eatment of conditions affecting the head

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Requirement Number - Roman		Reformatted Requirement	
	Requirement Language	Number	Requiremen
IV.B.1.b).(2).(b).(xvi)	traumatic disorders; (Core)	4.5.b.16.	traumatic disorders; (Core)
IV.B.1.b).(2).(b).(xvii)	vascular disorders; and, (Core)	4.5.b.17.	vascular disorders; and, (Core)
IV.B.1.b).(2).(b).(xviii)	vestibular and hearing disorders. (Core)	4.5.b.18.	vestibular and hearing disorders. (Core)
1 (P 1 h) (2) (a)	Residents should demonstrate competence in performing otolaryngologic	4.5.c.	Residents should demonstrate competer
IV.B.1.b).(2).(c)	procedures, including: (Core)	4.5.c.1.	procedures, including: (Core)
IV.B.1.b).(2).(c).(i)	airway management; (Core) computer-assisted navigation; (Core)	4.5.c.2.	airway management; (Core) computer-assisted navigation; (Core)
IV.B.1.b).(2).(c).(ii) IV.B.1.b).(2).(c).(iii)	endoscopy of the upper aerodigestive tract; (Core)	4.5.c.3.	endoscopy of the upper aerodigestive tra
	laser usage; (Core)	4.5.c.4.	laser usage; (Core)
IV.B.1.b).(2).(c).(iv)	local and regional anesthesia; (Core)	4.5.c.5.	local and regional anesthesia; (Core)
IV.B.1.b).(2).(c).(v)	resuscitation; (Core)	4.5.c.6.	resuscitation; (Core)
IV.B.1.b).(2).(c).(vi) IV.B.1.b).(2).(c).(vii)	stroboscopy; and, (Core)	4.5.c.7.	stroboscopy; and, (Core)
,,,,,,,	universal precautions. (Core)	4.5.c.8.	universal precautions. (Core)
IV.B.1.b).(2).(c).(viii)		4.5.0.0.	universal precautions. (Core)
IV.B.1.c)	Medical Knowledge Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)	4.6.	ACGME Competencies – Medical Kno Residents must demonstrate knowled biomedical, clinical, epidemiological, including scientific inquiry, as well as patient care. (Core)
IV.B.1.c).(1)	Residents must demonstrate knowledge appropriate for unsupervised practice of otolaryngology – head and neck surgery as defined by the ABOHNS curriculum. (Core)	4.6.a.	Residents must demonstrate knowledge of otolaryngology – head and neck surge curriculum. (Core)
IV.B.1.c).(2)	Residents must demonstrate knowledge of anatomy through procedural skills demonstrated in cadaver dissection, temporal bone lab, and/or surgical simulator labs. (Core)	4.6.b.	Residents must demonstrate knowledge demonstrated in cadaver dissection, tem simulator labs. (Core)
	Practice-based Learning and Improvement		
IV.B.1.d)	Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning; (Core)	4.7.	ACGME Competencies – Practice-Bas Residents must demonstrate the abili care of patients, to appraise and assin continuously improve patient care bas lifelong learning. (Core)
IV.B.1.d).(1)	Residents must demonstrate competence in:	[None]	
IV.B.1.d).(1).(a)	identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)	4.7.a.	Residents must demonstrate compete deficiencies, and limits in one's know
IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)	4.7.b.	Residents must demonstrate compete improvement goals. (Core)
IV.B.1.d).(1).(c)	identifying and performing appropriate learning activities; (Core)	4.7.c.	Residents must demonstrate compete appropriate learning activities. (Core)
IV.B.1.d).(1).(d)	systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)	4.7.d.	Residents must demonstrate competer practice using quality improvement m reducing health care disparities, and of practice improvement. (Core)
IV.B.1.d).(1).(e)	incorporating feedback and formative evaluation into daily practice; and, (Core)	4.7.e.	Residents must demonstrate competer formative evaluation into daily practic
IV.B.1.d).(1).(f)	locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)	4.7.f.	Residents must demonstrate competer assimilating evidence from scientific health problems. (Core)

tence in performing otolaryngologic

tract; (Core)

nowledge

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

ge appropriate for unsupervised practice gery as defined by the ABOHNS

ge of anatomy through procedural skills emporal bone lab, and/or surgical

ased Learning and Improvement ility to investigate and evaluate their similate scientific evidence, and to based on constant self-evaluation and

etence in identifying strengths, wledge and expertise. (Core) etence in setting learning and

etence in identifying and performing e)

etence in systematically analyzing methods, including activities aimed at d implementing changes with the goal

etence in incorporating feedback and tice. (Core)

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

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requirement
	Interpersonal and Communication Skills		
IV.B.1.e)	Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)	4.8.	ACGME Competencies – Interpersona Residents must demonstrate interpers result in the effective exchange of info patients, their families, and health pro
IV.B.1.e).(1)	Residents must demonstrate competence in	[None]	
IV.B.1.e).(1).(a)	communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)	4.8.a.	Residents must demonstrate compete with patients and patients' families, as of socioeconomic circumstances, cul capabilities, learning to engage interp provide appropriate care to each patie
IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; (Core)	4.8.b.	Residents must demonstrate compete with physicians, other health professi (Core)
IV.B.1.e).(1).(c)	working effectively as a member or leader of a health care team or other professional group; (Core)	4.8.c.	Residents must demonstrate competer member or leader of a health care team
IV.B.1.e).(1).(d)	educating patients, patients' families, students, other residents, and other health professionals; (Core)	4.8.d.	Residents must demonstrate competer families, students, other residents, an
IV.B.1.e).(1).(e)	acting in a consultative role to other physicians and health professionals; (Core)	4.8.e.	Residents must demonstrate competer to other physicians and health profes
IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible health care records, if applicable. (Core)	4.8.f.	Residents must demonstrate compete timely, and legible health care records
IV.B.1.e).(2)	Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)	4.8.g.	Residents must learn to communicate to partner with them to assess their ca appropriate, end-of-life goals. (Core)
IV.B.1.e).(3)	Residents must develop and present educational materials to the public. (Core)	4.8.h.	Residents must develop and present edu
	Systems-based Practice Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on		ACGME Competencies - Systems-Bas Residents must demonstrate an awar larger context and system of health ca social determinants of health, as well
IV.B.1.f).	other resources to provide optimal health care. (Core)	4.9.	other resources to provide optimal he
IV.B.1.f).(1) IV.B.1.f).(1).(a)	Residents must demonstrate competence in: working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)	[None] 4.9.a.	Residents must demonstrate compete health care delivery settings and syste specialty. ^(Core)
IV.B.1.f).(1).(b)	coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)	4.9.b.	Residents must demonstrate competer across the health care continuum and specialty. ^(Core)

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

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

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

etence in working effectively as a eam or other professional group. (Core)

etence in educating patients, patients' and other health professionals. (Core) etence in acting in a consultative role essionals. (Core)

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

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

educational materials to the public. (Core)

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

etence in working effectively in various stems relevant to their clinical

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
Numerais	advocating for quality patient care and optimal patient care systems;		Residents must demonstrate compete
IV.B.1.f).(1).(c)	(Core)	4.9.c.	care and optimal patient care systems
IV.B.1.f).(1).(d)	participating in identifying system errors and implementing potential systems solutions; (Core)	4.9.d.	Residents must demonstrate competers system errors and implementing pote
IV.B.1.f).(1).(e)	incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;(Core)	4.9.e.	Residents must demonstrate compete of value, equity, cost awareness, deliv analysis in patient and/or population-
IV.B.1.f).(1).(f)	understanding health care finances and its impact on individual patients' health decisions; and, (Core)	4.9.f.	Residents must demonstrate compete finances and its impact on individual
IV.B.1.f).(1).(g)	using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)	4.9.g.	Residents must demonstrate compete that promote patient safety and disclo simulated). ^(Detail)
	Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals,		Residents must learn to advocate for system to achieve the patient's and p
IV.B.1.f).(2)	including, when appropriate, end-of-life goals. (Core)	4.9.h.	including, when appropriate, end-of-li
IV.C.	Curriculum Organization and Resident Experiences	4.10 4.12.	 4.10. Curriculum Organization and Restructure The curriculum must be structured to experiences, the length of the experiences continuity. These educational experiences supervised patient care responsibilitiened educational events. (Core) 4.11. Curriculum Organization and Resclinical Experiences Residents must be provided with protoid didactic activities. (Core) 4.12. Curriculum Organization and Resclination and Rescl
IV.C.1.	The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)	4.10.	Curriculum Organization and Resider Structure The curriculum must be structured to experiences, the length of the experie continuity. These educational experie supervised patient care responsibiliti educational events. (Core)
IV.C.1.a)	Clinical rotations during the PGY-2-5 should be at least six weeks in length, and must be at least four weeks in length. (Core)	4.10.a.	Clinical rotations during the PGY-2-5 sho must be at least four weeks in length. (C

ent Language
etence in advocating for quality patient ems. (Core)
etence in participating in identifying
otential systems solutions. (Core)
etence in incorporating considerations
elivery and payment, and risk-benefit
on-based care as appropriate. (Core)
stan a la sur la sutta d'un la sutta sur
etence in understanding health care al patients' health decisions. (Core)
etence in using tools and techniques closure of patient safety events (real or
closure of patient salety events (real of
or patients within the health care
patient's family's care goals,
f-life goals. (Core)
Resident Experiences – Curriculum
to optimize resident educational
eriences, and the supervisory
riences include an appropriate blend of
lities, clinical teaching, and didactic
Desident Everyteness - Didectic and
Resident Experiences – Didactic and
rotected time to participate in core
Resident Experiences – Pain
ion and experience in pain
pecialty, including recognition of the
Core)
lent Experiences – Curriculum
to optimize resident educational
riences, and the supervisory
riences include an appropriate blend of
lities, clinical teaching, and didactic
should be at least six weeks in length, and
onour of a rouse on wooks in longer, and

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
			Curriculum Organization and Resider
	The program must provide instruction and experience in pain		The program must provide instruction
	management if applicable for the specialty, including recognition of the		management if applicable for the spe
IV.C.2.	signs of substance use disorder. (Core)	4.12.	signs of substance use disorder. (Co
	PGY-1 residents must participate in clinical and didactic activities in which they:		
IV.C.3.	(Core)	[None]	
			PGY-1 residents must participate in clini
	assess, plan, and initiate treatment of adult and pediatric patients with surgical	4.4.4 -	assess, plan, and initiate treatment of ad
IV.C.3.a)	and/or medical problems; (Core)	4.11.a.	and/or medical problems; (Core)
			PGY-1 residents must participate in clini
	care for patients of all ages with surgical and medical emergencies, multiple		care for patients of all ages with surgical
	organ system trauma, soft tissue wounds, nervous system injuries and	4 4 4 4	organ system trauma, soft tissue wounds
IV.C.3.b)	diseases, and peripheral vascular and thoracic injuries; (Core)	4.11.b.	diseases, and peripheral vascular and th
			PGY-1 residents must participate in clinic
	care for critically ill surgical and medical patients in the intensive care unit and	4 4 4 ~	care for critically ill surgical and medical
IV.C.3.c)	emergency room settings; (Core)	4.11.c.	emergency room settings; (Core)
			PGY-1 residents must participate in clinic
IV.C.3.d)	participate in the pre-, intra-, and post-operative care of surgical patients; and,	4.11.d.	participate in the pre-, intra-, and post-op (Core)
IV.C.3.u)	(Core)	4.11.u.	
			PGY-1 residents must participate in clinic
	participate in surgical anesthesia in hospital and ambulatory care settings,		participate in surgical anesthesia in hosp
IV.C.3.e)	including evaluation of anesthetic risks and the management of intra-operative anesthetic complications. (Core)	4.11.e.	including evaluation of anesthetic risks a anesthetic complications. (Core)
IV.C.4.	The PGY-1 must include:	[None]	
10.0.4.			
	six months of structured education on non-otolaryngology – head and neck		The PGY-1 must include six months of s
	surgery rotations designed to foster development of competence in the peri- operative care of surgical patients, inter-disciplinary care coordination, and		otolaryngology – head and neck surgery development of competence in the peri-
IV.C.4.a)	airway management skills; and, (Core)	4.11.f.	disciplinary care coordination, and airwa
10.0.4.0)	The total time a resident is assigned to any one non-otolaryngology – head and	T. I I.I.	The total time a resident is assigned to a
	neck surgery rotation must be at least four weeks and must not exceed two		neck surgery rotation must be at least fo
IV.C.4.a).(1)	months. (Core)	4.11.f.1.	months. (Core)
	Rotations must be selected from the following: anesthesia; emergency		Rotations must be selected from the follo
	medicine; general surgery; neurological surgery; neuroradiology;		medicine; general surgery; neurological
	ophthalmology; oral-maxillofacial surgery; pediatric surgery; plastic surgery;		ophthalmology; oral-maxillofacial surgery
IV.C.4.a).(2)	radiation oncology; and vascular surgery. (Core)	4.11.f.2.	radiation oncology; and vascular surgery
IV.C.4.a).(2).(a)	This must include a surgical or medical intensive care rotation. (Core)	4.11.f.2.a.	This must include a surgical or medical in
, , , , , ,	A one month or four-week night float rotation is permitted but must have		A one month or four-week night float rota
	structured educational goals and objectives, and the resident must be evaluated		structured educational goals and objectiv
IV.C.4.a).(2).(b)	during and at the end of the rotation. (Core)	4.11.f.2.b.	during and at the end of the rotation. (Co
	six months of otolaryngology – head and neck surgery rotations designed to		The PGY-1 must include six months of o
	develop competence in basic surgical skills, general care of otolaryngology –		rotations designed to develop competen
	head and neck surgery patients both in the inpatient setting and in the		of otolaryngology – head and neck surge
	outpatient clinics, management of otolaryngology – head and neck surgery		and in the outpatient clinics, management
	patients in the emergency department, and cultivation of an otolaryngology –		surgery patients in the emergency depar
IV.C.4.b)	head and neck surgery knowledge base. (Core)	4.11.g.	otolaryngology – head and neck surgery

ent Experiences – Pain Management: on and experience in pain ecialty, including recognition of the ore)

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

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

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

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

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

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

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

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

I intensive care rotation. (Core)

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
	The PGY-2-5 must include 48 months of progressive education in		The PGY-2-5 must include 48 months of
IV.C.5.	otolaryngology – head and neck surgery. (Core)	4.11.h.	otolaryngology – head and neck surgery
IV.C.6.	Each resident must spend a 12-month period as chief resident on the otolaryngology – head and neck surgery clinical service at the primary clinical site or one of the participating sites of the Sponsoring Institution during the last 24 months of the educational program. (Core)	4.11.i.	Each resident must spend a 12-month per otolaryngology – head and neck surgery site or one of the participating sites of the 24 months of the educational program. (
IV.C.7.	The educational program must provide at least three months of a structured research experience for residents. (Core)	4.11.j.	The educational program must provide a research experience for residents. (Core
IV.C.7.a)	While the three-month research experience need not be contiguous, each research rotation should not be less than one month in length. (Core)	4.11.j.1.	While the three-month research experien research rotation should not be less than
IV.C.7.a).(1)	Programs seeking to design a research curriculum with dedicated research experiences less than one month in length must first obtain approval from the Review Committee. (Core)	4.11.j.1.a.	Programs seeking to design a research of experiences less than one month in leng Review Committee. (Core)
IV.C.7.b)	The primary focus of this experience must be research and not clinical service or education. (Core)	4.11.j.2.	The primary focus of this experience mus or education. (Core)
IV.C.7.b).(1)	Concurrent clinical responsibilities must be limited. (Core)	4.11.j.2.a.	Concurrent clinical responsibilities must l
IV.C.7.c)	The research experience must include instruction in research methods and design, as well as outcome assessment. (Core)	4.11.j.3.	The research experience must include in design, as well as outcome assessment.
IV.C.8.	The didactic curriculum must include cyclical presentation of core specialty knowledge supplemented by the addition of breakthrough information. (Core)	4.11.k.	The didactic curriculum must include cyc knowledge supplemented by the addition
IV.C.9.	Educational conferences must include grand rounds, quality improvement conferences, morbidity and mortality conferences, and tumor conferences. (Core)	4.11.I.	Educational conferences must include gr conferences, morbidity and mortality con (Core)
IV.C.9.a)	Faculty members must participate in the preparation and presentation of educational conferences. (Core)	4.11.1.1.	Faculty members must participate in the educational conferences. (Core)
IV.C.9.b)	Residents must attend educational conferences. (Core)	4.11.I.2.	Residents must attend educational confe
IV.C.9.b).(1)	Each resident should attend at least 75 percent of the scheduled and held educational conferences. (Core)	4.11.l.2.a.	Each resident should attend at least 75 p educational conferences. (Core)
IV.C.9.b).(2)	Educational conferences must be evaluated. (Core)	4.11.l.2.b.	Educational conferences must be evalua
IV.C.9.c)	Didactic topics must include: basic sciences as relevant to the head and neck and upper-aerodigestive system; allergy and immunology; anatomy; biochemistry; cell biology; the communication sciences, including audiology, speech and language pathology, and the voice sciences, as they relate to laryngology; embryology; genetics; microbiology; pathology; pharmacology; physiology; rhinology; and the chemical senses, endocrinology, and neurology, as they relate to the head and neck. (Core)	4.11.1.3.	Didactic topics must include: basic scient and upper-aerodigestive system; allergy biochemistry; cell biology; the communic speech and language pathology, and the laryngology; embryology; genetics; micro physiology; rhinology; and the chemical s as they relate to the head and neck. (Con
	Anatomy should include the study and dissection of anatomic specimens, including the temporal bone, and procedural skills laboratories, along with		Anatomy should include the study and di including the temporal bone, and proced
IV.C.9.c).(1)	appropriate lectures and other formal sessions. (Detail)	4.11.I.3.a.	appropriate lectures and other formal see
IV.C.9.c).(2)	Pathology should include formal instruction in correlative pathology, including gross and microscopic pathology relating to the head and neck. (Detail)	4.11.I.3.b.	Pathology should include formal instructi gross and microscopic pathology relating
IV.C.9.c).(2).(a)	Residents should study and discuss with the pathology service tissues removed at operations and autopsy material. (Detail)	4.11.I.3.b.1.	Residents should study and discuss with at operations and autopsy material. (Deta

of progressive education in ry. (Core)

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

e at least three months of a structured re)

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

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

nust be research and not clinical service

t be limited. (Core)

instruction in research methods and nt. (Core)

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

grand rounds, quality improvement onferences, and tumor conferences.

e preparation and presentation of

ferences. (Core)

5 percent of the scheduled and held

uated. (Core)

ences as relevant to the head and neck gy and immunology; anatomy; nication sciences, including audiology, he voice sciences, as they relate to crobiology; pathology; pharmacology; al senses, endocrinology, and neurology, Core)

dissection of anatomic specimens, edural skills laboratories, along with sessions. (Detail)

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

th the pathology service tissues removed etail)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
			Resident Supervision and Patient Care E
IV.C.10.	Resident Supervision and Patient Care Experiences	4.11.m.	Residents must have experience with sta technology in otolaryngology – head and
V(C, 10, c)	Residents must have experience with state-of-the-art advances and emerging	4.11 m	Resident Supervision and Patient Care E Residents must have experience with sta
IV.C.10.a)	technology in otolaryngology – head and neck surgery. (Core)	4.11.m.	technology in otolaryngology – head and
IV.C.10.b)	Residents must perform a sufficient number, variety, and complexity of surgical procedures to ensure education in the entire scope of the specialty. (Core)	4.11.m.1.	Residents must perform a sufficient num procedures to ensure education in the er
IV.C.10.b).(1)	Residents must have essentially equivalent distributions of case categories and procedures. (Core)	4.11.m.1.a.	Residents must have essentially equivale procedures. (Core)
IV.C.10.c)	Residents must have a broad range of experience in otolaryngology – head and neck surgery through outpatient care. This must include: (Core)	4.11.m.2.	Residents must have a broad range of ex neck surgery through outpatient care. Th
IV.C.10.c).(1)	exposure to clinical aspects of diagnosis, medical and/or surgical therapy, and prevention of and rehabilitation from diseases, neoplasms, deformities, disorders, and/or injuries of the ears, upper respiratory and upper alimentary systems, face, jaws, and other head and neck systems; to head and neck oncology; and to facial plastic and reconstructive surgery; (Core)	4.11.m.2.a.	exposure to clinical aspects of diagnosis prevention of and rehabilitation from dise disorders, and/or injuries of the ears, upp systems, face, jaws, and other head and oncology; and to facial plastic and recons
IV.C.10.c).(2)	evaluating patients, establishing provisional diagnoses, and initiating preliminary treatment plans; and, (Core)	4.11.m.2.b.	evaluating patients, establishing provisio treatment plans; and, (Core)
IV.C.10.c).(3)	providing follow-up care and evaluating the results of surgical care. (Core)	4.11.m.2.c.	providing follow-up care and evaluating t
IV.C.10.d)	Residents should have experience in the management of office practice. (Detail)	4.11.m.3.	Residents should have experience in the
IV.C.10.e)	Residents must have experience in the emergency care of critically ill and injured patients with otolaryngologic conditions. (Core)	4.11.m.4.	Residents must have experience in the e injured patients with otolaryngologic cond
IV.C.10.f)	Each resident must have patient care responsibility commensurate with his or her knowledge, problem-solving ability, manual skills, and experience, as well as with the severity and complexity of each patient's status. (Core)	4.11.m.5.	Each resident must have patient care res her knowledge, problem-solving ability, n as with the severity and complexity of ea
IV.C.10.f).(1)	This must include experience as assistant surgeon and resident supervisor. (Core)	4.11.m.5.a.	This must include experience as assistar (Core)
IV.C.10.f).(2)	All levels of surgical intervention must be recorded in the ACGME Case Log System. (Core)	4.11.m.5.b.	All levels of surgical intervention must be System. (Core)
IV.C.11.	International Rotations	4.11.n.	International Rotations International rotations must be approved
IV.C.11.a)	International rotations must be approved by the program director. (Core)	4.11.n.	International Rotations International rotations must be approved
,	The total time spent in international rotations should be no more than one month		The total time spent in international rotat
IV.C.11.b)	over the five-year program. (Detail)	4.11.n.1.	over the five-year program. (Detail)
IV.C.11.c)	All institutional policies and procedures that govern the program at the sponsoring institution must continue to be in effect for residents during an international rotation. (Core)	4.11.n.2.	All institutional policies and procedures the sponsoring institution must continue to be international rotation. (Core)
IV.C.11.d)	Surgical procedures completed during an international rotation must not be counted toward meeting the required minima of procedures. (Core)	4.11.n.3.	Surgical procedures completed during ar counted toward meeting the required mir

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

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

mber, variety, and complexity of surgical entire scope of the specialty. (Core) alent distributions of case categories and

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

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

ional diagnoses, and initiating preliminary

g the results of surgical care. (Core)

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

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

be recorded in the ACGME Case Log

ed by the program director. (Core)

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

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

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

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requiremen
	Scholarship		Scholarship
	Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.		Medicine is both an art and a science scientist who cares for patients. This evaluate the literature, appropriately a practice lifelong learning. The progra environment that fosters the acquisit participation in scholarly activities. So discovery, integration, application, ar
IV.D.	The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.	[None]	The ACGME recognizes the diversity programs prepare physicians for a va scientists, and educators. It is expect will reflect its mission(s) and aims, 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 with its mission(s) and aims. (Core)
IV.D.1.a)	The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)	4.13.	Program Responsibilities The program must demonstrate evide with its mission(s) and aims. (Core)
IV.D.1.b)	The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)	4.13.a.	The program, in partnership with its adequate resources to facilitate resid scholarly activities. (Core)
IV.D.1.c)	The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)	4.13.b.	The program must advance residents scholarly approach to evidence-base
			Faculty Scholarly Activity Among their scholarly activity, progra accomplishments in at least three of t
			 Research in basic science, educatio or population health Peer-reviewed grants Quality improvement and/or patient Systematic reviews, meta-analyses, textbooks, or case reports
IV.D.2.	Faculty Scholarly Activity	4.14.	 Creation of curricula, evaluation too electronic educational materials Contribution to professional commit editorial boards Innovations in education
14.0.2.		4.14.	

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

ty of residencies 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 pulation health, and/or teaching, while ilize more classic forms of biomedical nip.

dence of scholarly activities consistent

dence of scholarly activities consistent

s Sponsoring Institution, must allocate ident and faculty involvement in

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

grams must demonstrate of the following domains: (Core)

ion, translational science, patient care,

nt safety initiatives s, review articles, chapters in medical

ools, didactic educational activities, or

nittees, educational organizations, or

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

rams must demonstrate f the following domains: (Core)

ion, translational science, patient care,

t safety initiatives s, review articles, chapters in medical

ools, didactic educational activities, or

nittees, educational organizations, or

semination of scholarly activity within following methods:

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

me)

semination of scholarly activity within following methods:

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

me)

Requirement		Reformatted	
Number - Roman	De suizement Les suese	Requirement	Denvironnen
Numerals	Requirement Language	Number	Requiremen
			The program must demonstrate disse and external to the program by the fo
			faculty participation in grand round
			improvement presentations, podium
			peer-reviewed print/electronic resource
			chapters, textbooks, webinars, servic serving as a journal reviewer, journal
			(Outcome)
IV.D.2.b).(2)	peer-reviewed publication. (Outcome)	4.14.a.	peer-reviewed publication. (Outcom
			Resident Scholarly Activity
IV.D.3.	Resident Scholarly Activity	4.15.	Residents must participate in scholar
			Resident Scholarly Activity
IV.D.3.a)	Residents must participate in scholarship. (Core)	4.15.	Residents must participate in scholar
	The research experience (Program Requirement IV.C.7) should result in a		The research experience (Program Req
IV.D.3.a).(1)	completed manuscript suitable for publication in a peer-reviewed journal. (Outcome)	4.15.a.	completed manuscript suitable for public (Outcome)
V.	Evaluation	Section 5	Section 5: Evaluation
••			Resident Evaluation: Feedback and E
			Faculty members must directly obser
			feedback on resident performance du
V.A.	Resident Evaluation	5.1.	educational assignment. (Core)
			Resident Evaluation: Feedback and E
			Faculty members must directly obser
			feedback on resident performance du
V.A.1.	Feedback and Evaluation	5.1.	educational assignment. (Core)
			Resident Evaluation: Feedback and E
	Faculty members must directly observe, evaluate, and frequently provide		Faculty members must directly obser
V.A.1.a)	feedback on resident performance during each rotation or similar educational assignment. (Core)	5.1.	feedback on resident performance du educational assignment. (Core)
•. 	Evaluation must be documented at the completion of the assignment.	U. I.	Evaluation must be documented at th
V.A.1.b)	(Core)	5.1.a.	(Core)
	For block rotations of greater than three months in duration, evaluation		For block rotations of greater than the
V.A.1.b).(1)	must be documented at least every three months. (Core)	5.1.a.1.	must be documented at least every th
	Longitudinal experiences, such as continuity clinic in the context of other		Longitudinal experiences, such as co
l	clinical responsibilities, must be evaluated at least every three months		clinical responsibilities, must be eval
V.A.1.b).(2)	and at completion. (Core)	5.1.a.2.	and at completion. (Core)
			The program must provide an objecti
	The program must provide an objective performance evaluation based on		the Competencies and the specialty-s
V.A.1.c)	the Competencies and the specialty-specific Milestones, and must: (Core)	5.1.b.	
	use multiple evaluators (e.g., faculty members, peers, patients, self, and		The program must use multiple evalu
V.A.1.c).(1)	other professional staff members); and, (Core)	5.1.b.1.	patients, self, and other professional
	provide that information to the Clinical Competency Committee for its		The program must provide that inform
$V \wedge 1 \sim (2)$	synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)	5.1.b.2.	Committee for its synthesis of progre improvement toward unsupervised progrematics of the synthesis of the s
V.A.1.c).(2)	luiisuhei viseu hiaciice. (COIE)	J. I.J.Z.	Improvement toward unsupervised pl

semination of scholarly activity within following methods:

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

ome)

larship. (Core)

larship. (Core)

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

Evaluation

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

Evaluation

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

Evaluation

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

the completion of the assignment.

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

continuity clinic in the context of other valuated at least every three months

ctive performance evaluation based on y-specific Milestones. ^(Core)

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

prmation to the Clinical Competency pressive resident performance and practice. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:	[None]	· · · · · ·
V.A.1.d).(1)	meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)		The program director or their designe Competency Committee, must meet w their documented semi-annual evalua progress along the specialty-specific
V.A.1.d).(1).(a)	This must include review of the resident's cumulative operative experience at least semiannually to ensure balanced progress towards achieving experience with a variety and complexity of surgical procedures. (Core)	5.1.c.1.	This must include review of the resident' least semiannually to ensure balanced p with a variety and complexity of surgical
V.A.1.d).(2)	assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)	5.1.d.	The program director or their designe Competency Committee, must assist individualized learning plans to capita areas for growth. (Core)
V.A.1.d).(3)	develop plans for residents failing to progress, following institutional policies and procedures. (Core)	5.1.e.	The program director or their designe Competency Committee, must develo progress, following institutional polic
V.A.1.e)	At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)	5.1.f.	At least annually, there must be a sun that includes their readiness to progra applicable. (Core)
V.A.1.e).(1)	Residents must participate in existing national examinations. (Core)	5.1.f.1.	Residents must participate in existing na
	Use of the annual Otolaryngology – Head and Neck Surgery Training		Use of the annual Otolaryngology – Hea
V.A.1.e).(1).(a)	Examination is strongly suggested.	5.1.f.1.a.	Examination is strongly suggested.
V.A.1.e).(1).(b)	An analysis of the results of these testing programs must be limited to guiding faculty members in assessing the strengths and weaknesses of the program and individual residents. (Core)	5.1.f.1.b.	An analysis of the results of these testing faculty members in assessing the streng and individual residents. (Core)
V.A.1.e).(2)	The faculty must meet annually to provide collective evaluation of each resident, including surgical competence, and must provide an annual summative report for each resident. (Core)	5.1.f.2.	The faculty must meet annually to provid including surgical competence, and mus for each resident. (Core)
V.A.1.f).	The evaluations of a resident's performance must be accessible for review by the resident. (Core)		The evaluations of a resident's perfor by the resident. (Core)
V.A.2.	Final Evaluation	5.2.	Resident Evaluation: Final Evaluation The program director must provide a upon completion of the program. (Con
	The program director must provide a final evaluation for each resident		Resident Evaluation: Final Evaluation The program director must provide a
V.A.2.a)	upon completion of the program. (Core)	5.2.	upon completion of the program. (Co
V.A.2.a).(1)	The specialty-specific Milestones, and when applicable the specialty- specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)	5.2.a.	The specialty-specific Milestones, and specific Case Logs, must be used as engage in autonomous practice upon
V.A.2.a).(2)	The final evaluation must:	[None]	
V.A.2.a).(2).(a)	become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)	5.2.b.	The final evaluation must become par maintained by the institution, and must resident in accordance with institution

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

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

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

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

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

national examinations. (Core) ead and Neck Surgery Training

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

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

ormance must be accessible for review

on

a final evaluation for each resident core)

on

a final evaluation for each resident core)

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

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

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

the resident has demonstrated the cessary to enter autonomous practice.

with the resident upon completion of

nust be appointed by the program

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

/ members from the same program or fessionals who have extensive contact residents. (Core)

e must review all resident evaluations

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

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

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

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

ew of the faculty member's clinical the educational program, participation eir skills as an educator, clinical scholarly activities. (Core) n, anonymous, and confidential

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back on their evaluations at least

valuations should be incorporated into plans. (Core)

ent

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

Requirement Language	Reformatted Requirement Number	Requirement La
The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)	5.5.	Program Evaluation and Improvement The program director must appoint the F conduct and document the Annual Prog program's continuous improvement pro
The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)	5.5.a.	The Program Evaluation Committee mus program faculty members, at least one o and at least one resident. (Core)
Program Evaluation Committee responsibilities must include:	[None]	
review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee responsion program's self-determined goals and program's self-determined goals and program and pr
guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee responsion ongoing program improvement, includin based upon outcomes. (Core)
review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee responsi current operating environment to identif opportunities, and threats as related to t (Core)
The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)	5.5.e.	The Program Evaluation Committee show prior Annual Program Evaluation(s), agg evaluations of the program, and other re the program. (Core)
The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)	5.5.f.	The Program Evaluation Committee mus and aims, strengths, areas for improvem
The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)	5.5.g.	The Annual Program Evaluation, includin distributed to and discussed with the res teaching faculty, and be submitted to the
The program must complete a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must complete a Self-Study
One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.		Board Certification One goal of ACGME-accredited educatio seek and achieve board certification. On the educational program is the ultimate p
The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.	[None]	The program director should encourage take the certifying examination offered b of Medical Specialties (ABMS) member b Association (AOA) certifying board.
For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.	Board Certification For specialties in which the ABMS members board offer(s) an annual written exam, in program's aggregate pass rate of those time must be higher than the bottom fifth specialty. (Outcome)
	The program 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) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core) Program Evaluation Committee responsibilities must include: review of the program's self-determined goals and progress toward meeting them; (Core) guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core) review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core) The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core) The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core) 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 Dosard of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board. For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that	Requirement Language Requirement Number 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. The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core) 5.5.a. Program Evaluation Committee responsibilities must include: [None] review of the program's self-determined goals and progress toward meeting them; (Core) 5.5.c. guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core) 5.5.c. review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core) 5.5.d. The Program Evaluation Committee should consider the outcomes from prior Annual Program, and other relevant data in its assessment of the program. (Core) 5.5.f. The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core) 5.5.f. The Program Evaluation Committee must evaluate the program's mission and aims. strengths, areas for improvement, and threats. (Core) 5.5.f. The Program Evaluation is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the education al porgram is the ultimate pass rate. 5.5.h. </td

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

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

oonsibilities must include review of the d progress toward meeting them. ^(Core)

oonsibilities must include guiding 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 resident and faculty written er relevant data in its assessment of

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

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

Study and submit it to the DIO. (Core)

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

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

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

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requiremen
V.C.3.b)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.a.	For specialties in which the ABMS me board offer(s) a biennial written exam program's aggregate pass rate of tho time must be higher than the bottom specialty. ^(Outcome)
V.C.3.c)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.b.	For specialties in which the ABMS me board offer(s) an annual oral exam, in program's aggregate pass rate of tho time must be higher than the bottom specialty. ^(Outcome)
V.C.3.d)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.c.	For specialties in which the ABMS me board offer(s) a biennial oral exam, in program's aggregate pass rate of tho time must be higher than the bottom specialty. ^(Outcome)
V.C.3.e)	For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)	5.6.d.	For each of the exams referenced in 5 graduates over the time period specif an 80 percent pass rate will have met percentile rank of the program for pas
V.C.3.f)	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)	5.6.e.	Programs must report, in ADS, board cohort of board-eligible residents tha
	The Learning and Working Environment		Section 6: The Learning and Working The Learning and Working Environme
	Residency education must occur in the context of a learning and working environment that emphasizes the following principles:		Residency education must occur in the environment that emphasizes the following the fo
	 Excellence in the safety and quality of care rendered to patients by residents today 		• Excellence in the safety and quality residents today
	 Excellence in the safety and quality of care rendered to patients by today's residents in their future practice 		• Excellence in the safety and quality today's residents in their future pract
	• Excellence in professionalism		• Excellence in professionalism
	• Appreciation for the privilege of caring for patients		• Appreciation for the privilege of car
vi	 Commitment to the well-being of the students, residents, faculty members, and all members of the health care team 	Section 6	• Commitment to the well-being of the members, and all members of the heat
VI.A.	Patient Safety, Quality Improvement, Supervision, and Accountability	[None]	
VI.A.1.	Patient Safety and Quality Improvement	[None]	
VI.A.1.a)	Patient Safety	[None]	

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

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

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

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

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

ng Environment

ment

the context of a learning and working ollowing principles:

ty of care rendered to patients by

ty of care rendered to patients by octice

aring for patients

the students, residents, faculty realth care team

Requirement		Reformatted	
Number - Roman	De multiment de marca de	Requirement	
Numerals	Requirement Language	Number	Requirement
	Culture of Safety		Culture of Safety
	A culture of safety requires continuous identification of vulnerabilities		A culture of safety requires continuou
	and a willingness to transparently deal with them. An effective		and a willingness to transparently dea
	organization has formal mechanisms to assess the knowledge, skills, and		organization has formal mechanisms
	attitudes of its personnel toward safety in order to identify areas for		attitudes of its personnel toward safet
VI.A.1.a).(1)	improvement.	[None]	improvement.
	The program, its faculty, residents, and fellows must actively participate in		The program, its faculty, residents, an
VI.A.1.a).(1).(a)		6.1.	patient safety systems and contribute
l	Patient Safety Events		Detient Sefety Events
	Reporting, investigation, and follow-up of safety events, near misses, and		Patient Safety Events Reporting, investigation, and follow-u
	unsafe conditions are pivotal mechanisms for improving patient safety,		unsafe conditions are pivotal mechan
	and are essential for the success of any patient safety program. Feedback		and are essential for the success of a
	and experiential learning are essential to developing true competence in		and experiential learning are essential
	the ability to identify causes and institute sustainable systems-based		the ability to identify causes and instit
VI.A.1.a).(2)		[None]	changes to ameliorate patient safety v
	Residents, fellows, faculty members, and other clinical staff members	[None]	
VI.A.1.a).(2).(a)	must:	[None]	Desidente felleure feeultumembere :
	know their responsibilities in reporting patient safety events and unsafe		Residents, fellows, faculty members, a must know their responsibilities in rep
	conditions at the clinical site, including how to report such events; and,		unsafe conditions at the clinical site, i
VI.A.1.a).(2).(a).(i)		6.2.	(Core)
			Residents, fellows, faculty members, a
	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)
	Residents must participate as team members in real and/or simulated		Residents must participate as team m
l	interprofessional clinical patient safety and quality improvement activities,		interprofessional clinical patient safet
	such as root cause analyses or other activities that include analysis, as		such as root cause analyses or other
VI.A.1.a).(2).(b)	•	6.3.	well as formulation and implementation
	Quality Metrics		
	Access to data is accountial to prioritizing activities for some improvement		Quality Metrics
VI.A.1.a).(3)	Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.	[None]	Access to data is essential to prioritiz and evaluating success of improvement
	Residents and faculty members must receive data on quality metrics and		Residents and faculty members must
VI.A.1.a).(3).(a)		6.4.	benchmarks related to their patient po

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

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

t-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.

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

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

tizing activities for care improvement ment efforts. st receive data on quality metrics and populations. (Core)

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

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

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

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

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

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

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

at the appropriate level of supervision in each resident's level of training and y and acuity. Supervision may be nods, as appropriate to the situation.

Requirement		Reformatted	
Number - Roman Numerals	Requirement Language	Requirement Number	Requirement
	Levels of Supervision		
			Levels of Supervision
	To promote appropriate resident supervision while providing for graded		To promote appropriate resident supe
VI.A.2.b)	authority and responsibility, the program must use the following classification of supervision:	[None]	authority and responsibility, the program classification of supervision.
VI.A.2.0)			
			Direct Supervision
			The supervising physician is physical
			the key portions of the patient interac
			The supervising physician and/or path
			the resident and the supervising phys
VI.A.2.b).(1)	Direct Supervision	6.7.	patient care through appropriate telec
			Direct Supervision
			The supervising physician is physical
			the key portions of the patient interac
			The supervising physician and/or path
	the supervising physician is physically present with the resident during		the resident and the supervising phys
VI.A.2.b).(1).(a)	the key portions of the patient interaction.	6.7.	patient care through appropriate telec
VI.A.2.b).(1).(a).(i)	PGY-1 residents must initially be supervised directly, only as described in VI.A.2.b).(1).(a). (Core)	6.7.a.	PGY-1 residents must initially be super the above definition. (Core)
	Each program must define those physician tasks for which PGY-1 residents		Each program must define those physici
	must be supervised directly until they have demonstrated competence as		must be supervised directly until they ha
VI.A.2.b).(1).(a).(i).(a)	defined by the program director, and must maintain records of such demonstrations of competence. (Core)	6.7.a.1.	defined by the program director, and mudemonstrations of competence. (Core)
	Each program must define those physician tasks for which PGY-1 residents		Each program must define those physici
	may be supervised indirectly with direct supervision available, and must define	0.7.0	may be supervised indirectly with direct
VI.A.2.b).(1).(a).(i).(b)	"direct supervision" in the context of the individual program. (Core)	6.7.a.2.	"direct supervision" in the context of the
			Direct Supervision
			The supervising physician is physical
			the key portions of the patient interac
	the supervising physician and/or patient is not physically present with the		The supervising physician and/or path
	resident and the supervising physician is concurrently monitoring the		the resident and the supervising phys
VI.A.2.b).(1).(b)	patient care through appropriate telecommunication technology. (Core)	6.7.	patient care through appropriate telec
VI.A.2.b).(1).(b).(i)	Supervision through telecommunication technology must be limited to residents at the PGY-2 level and above. (Core)	6.7.b.	Supervision through telecommunication at the PGY-2 level and above. (Core)
	Indirect Supervision: the supervising physician is not providing physical		Indirect Supervision
	or concurrent visual or audio supervision but is immediately available to		The supervising physician is not prov
VI.A.2.b).(2)	• • • • •	[None]	-
VI.A.2.b).(2)	the resident for guidance and is available to provide appropriate direct supervision.	[None]	or audio supervision but is immedia guidance and is available to provide

pervision while providing for graded gram must use the following

cally present with the resident during action.

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

cally present with the resident during action.

atient is not physically present with ysician is concurrently monitoring the ecommunication technology. pervised directly, only as described in

ician tasks for which PGY-1 residents nave demonstrated competence as nust maintain records of such

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

cally present with the resident during action.

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

n technology must be limited to residents

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

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requirement
VI.A.2.b).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. The program must define when physical presence of a supervising	[None]	Oversight The supervising physician is available procedures/encounters with feedback The program must define when physic
VI.A.2.c)	physician is required. (Core)	6.8.	physician is required. (Core)
VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)	6.9.	The privilege of progressive authority independence, and a supervisory role resident must be assigned by the prog (Core)
VI.A.2.d).(1)	The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)	6.9.a.	The program director must evaluate e specific criteria, guided by the Milesto
VI.A.2.d).(2)	Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)	6.9.b.	Faculty members functioning as supe portions of care to residents based or skills of each resident. (Core)
VI.A.2.d).(3)	Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)		Senior residents or fellows should ser residents in recognition of their progr the needs of each patient and the skill (Detail)
VI.A.2.e)	Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)	6.10.	Programs must set guidelines for circ residents must communicate with the (Core)
VI.A.2.e).(1)	Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)	6.10.a.	Each resident must know the limits of circumstances under which the reside conditional independence. (Outcome)
VI.A.2.f)	Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)	6.11.	Faculty supervision assignments must the knowledge and skills of each resident the appropriate level of patient care an
VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with their Sp residents and faculty members conce responsibilities of physicians, includi to be appropriately rested and fit to pr patients. (Core)
VI.B.1.	Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)	6.12.	Professionalism Programs, in partnership with their Sp residents and faculty members conce responsibilities of physicians, includi to be appropriately rested and fit to pr patients. (Core)
VI.B.2.	The learning objectives of the program must:	[None]	
VI.B.2.a)	be accomplished without excessive reliance on residents to fulfill non- physician obligations; (Core)	6.12.a.	The learning objectives of the programe excessive reliance on residents to full

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 ogram director and faculty members.

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

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

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

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

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

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

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

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the program
VI.B.2.c)	include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)	6.12.c.	The learning objectives of the program the meaning that each resident finds physician, including protecting time v administrative support, promoting pro flexibility, and enhancing professiona
VI.B.3.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)		The program director, in partnership provide a culture of professionalism t personal responsibility. (Core)
VI.B.4.	Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)	6.12.e.	Residents and faculty members must their personal role in the safety and w care, including the ability to report un (Core)
VI.B.5.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)	6.12.f.	Programs, in partnership with their Sp a professional, equitable, respectful, a psychologically safe and that is free f forms of harassment, mistreatment, a residents, faculty, and staff. (Core)
VI.B.6.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)	6.12.g.	Programs, in partnership with their Sp process for education of residents an 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 residency training.		Well-Being Psychological, emotional, and physic development of the competent, caring proactive attention to life inside and o requires that physicians retain the joy own real-life stresses. Self-care and re members of the health care team are professionalism; they are also skills to nurtured in the context of other aspect
VI.C.	Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.	[None]	Residents and faculty members are a Programs, in partnership with their Sp same responsibility to address well-b competence. Physicians and all mem- responsibility for the well-being of ea clinical learning environment models prepares residents with the skills and throughout their careers.
VI.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)	attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)	6.13.a.	attention to scheduling, work intensit impacts resident well-being; (Core)

am must ensure manageable patient

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

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

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

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

Sponsoring Institutions, should have a and faculty regarding unprofessional 6 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 residency training.

at 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 Is constructive behaviors, and nd attitudes needed to thrive

n partnership with the Sponsoring

sity, and work compression that

Requirement		Reformatted	
Number - Roman		Requirement	
Numerals	Requirement Language	Number	Requirement Language
	evaluating workplace safety data and addressing the safety of residents		evaluating workplace safety data and addressing the safety of residents
VI.C.1.b)	and faculty members; (Core)	6.13.b.	and faculty members; (Core)
	policies and programs that encourage optimal resident and faculty		policies and programs that encourage optimal resident and faculty
VI.C.1.c)	member well-being; and, (Core)	6.13.c.	member well-being; and, (Core)
	Residents must be given the opportunity to attend medical, mental health,		Residents must be given the opportunity to attend medical, mental health,
	and dental care appointments, including those scheduled during their		and dental care appointments, including those scheduled during their
VI.C.1.c).(1)	working hours. (Core)	6.13.c.1.	working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty members in:
	identification of the symptoms of burnout, depression, and substance use		identification of the symptoms of burnout, depression, and substance use
	disorders, suicidal ideation, or potential for violence, including means to		disorders, suicidal ideation, or potential for violence, including means to
VI.C.1.d).(1)	assist those who experience these conditions; (Core)	6.13.d.1.	assist those who experience these conditions; (Core)
	recognition of these symptoms in themselves and how to seek	6.13.d.2.	recognition of these symptoms in themselves and how to seek
VI.C.1.d).(2)	appropriate care; and, (Core)		appropriate care; and, (Core)
VI.C.1.d).(3)	access to appropriate tools for self-screening. (Core)	6.13.d.3.	access to appropriate tools for self-screening. (Core)
	providing access to confidential, affordable mental health assessment,		providing access to confidential, affordable mental health assessment,
	counseling, and treatment, including access to urgent and emergent care	0.40 -	counseling, and treatment, including access to urgent and emergent care
VI.C.1.e)	24 hours a day, seven days a week. (Core)	6.13.e.	24 hours a day, seven days a week. (Core)
	There are circumstances in which residents may be unable to attend work,		There are circumstances in which residents may be unable to attend work
	including but not limited to fatigue, illness, family emergencies, and		including but not limited to fatigue, illness, family emergencies, and
	medical, parental, or caregiver leave. Each program must allow an		medical, parental, or caregiver leave. Each program must allow an
	appropriate length of absence for residents unable to perform their patient		appropriate length of absence for residents unable to perform their patient
VI.C.2.	care responsibilities. (Core)	6.14.	care responsibilities. (Core)
	The program must have policies and procedures in place to ensure	6.14.a.	The program must have policies and procedures in place to ensure
VI.C.2.a)		0.14.a.	coverage of patient care and ensure continuity of patient care. (Core)
	These policies must be implemented without fear of negative		These policies must be implemented without fear of negative
	consequences for the resident who is or was unable to provide the clinical		consequences for the resident who is or was unable to provide the clinical
VI.C.2.b)	work. (Core)	6.14.b.	work. (Core)
			Fatigue Mitigation
			Programs must educate all residents and faculty members in recognition
	Estique Mitigation	6.15.	of the signs of fatigue and sleep deprivation, alertness management, and
VI.D.	Fatigue Mitigation	0.15.	fatigue mitigation processes. (Detail)
			Fatigue Mitigation
	Programs must educate all residents and faculty members in recognition		Programs must educate all residents and faculty members in recognition
	of the signs of fatigue and sleep deprivation, alertness management, and	6.15.	of the signs of fatigue and sleep deprivation, alertness management, and
VI.D.1.		0.10.	fatigue mitigation processes. (Detail)
	The program, in partnership with its Sponsoring Institution, must ensure		The program, in partnership with its Sponsoring Institution, must ensure
VI.D.2.	adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)	6.16.	adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)
VI.D.2. VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
VI.L.			
	Clinical Responsibilities		Clinical Deenensibilities
	The clinical reasonabilities for each resident must be based on DOV lawel		Clinical Responsibilities
	The clinical responsibilities for each resident must be based on PGY level,		The clinical responsibilities for each resident must be based on PGY level,
	patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)	6.17.	patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)
VI.E.1.	Innessicululuun, allu available support services. (Core)	0.17.	Innessicululuun, allu avallable support services. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
VI.E.1.a)	The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Detail)	6.17.a.	The workload associated with optimal cli continuum from the moment of admissio
VI.E.1.b)	During the residency education process, surgical teams should be made up of attending surgeons, residents at various PGY levels, medical students (when appropriate), and other health care providers. (Detail)	6.17.b.	During the residency education process, attending surgeons, residents at various appropriate), and other health care provi
VI.E.1.c)	The work of the caregiver team should be assigned to team members based on each resident's level of education, experience, and competence. (Detail)	6.17.c.	The work of the caregiver team should b each resident's level of education, exper
VI.E.2.	Teamwork Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)	6.18.	Teamwork Residents must care for patients in ar communication and promotes safe, in the specialty and larger health system
VI.E.2.a)	Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff members). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Detail)	6.18.a.	Effective surgical practices entail the invector complementary skills and attributes (phy members). Success requires both an un- and contributions, and a shared commitr (Detail)
VI.E.2.b)	Residents must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Core)	6.18.b.	Residents must collaborate with fellow s faculty members, other physicians outsic health care providers, to best formulate t diverse patient population. (Core)
VI.E.2.c)	Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. (Core)	6.18.c.	Residents must assume personal respor they are assigned (or which they volunta tasks must be completed in the hours as residents must learn and utilize the estal remaining tasks to another member of th not compromised. (Core)
VI.E.2.d)	Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Core)	6.18.d.	Lines of authority should be defined by p working knowledge of these expected re quality care and patient safety. (Core)
VI.E.3.	Transitions of Care	6.19.	Transitions of Care Programs must design clinical assign patient care, including their safety, fre
VI.E.3.a)	Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)	6.19.	Transitions of Care Programs must design clinical assign patient care, including their safety, fre
VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)	6.19.a.	Programs, in partnership with their Sp and monitor effective, structured han continuity of care and patient safety.
VI.E.3.c)	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)	6.19.b.	Programs must ensure that residents with team members in the hand-off pr

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

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

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

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

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

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

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

programs, and all residents must have a reporting relationships to maximize

nments 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)

ts are competent in communicating process. (Outcome)

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

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

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

rk and Education off between scheduled clinical work

rk and Education off between scheduled clinical work

urs free of clinical work and education e)

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

ion Period Length

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

ion Period Length

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

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

Exceptions

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

Requirement Number - Roman		Reformatted Requirement	
Numerals	Requirement Language	Number	Requiremen
VI.F.4.a)	In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)	6.23.	Clinical and Educational Work Hour E In rare circumstances, after handing or resident, on their own initiative, may or clinical site in the following circumsta a single severely ill or unstable patier needs of a patient or patient's family; events. (Detail)
VI.F.4.b)	These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)	6.23.a.	These additional hours of care or edu 80-hour weekly limit. (Detail)
	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 rotati percent or a maximum of 88 clinical a individual programs based on a soun
VI.F.4.c)	The Review Committee for Otolaryngology – Head and Neck Surgery will not consider requests for exceptions to the 80-hour limit to the residents' work week.	6.24.	The Review Committee for Otolaryngolo consider requests for exceptions to the 8 week.
VI.F.5.	Moonlighting	6.25.	Moonlighting Moonlighting must not interfere with the goals and objectives of the educa interfere with the resident's fitness fo safety. (Core)
VI.F.5.a)	Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)	6.25.	Moonlighting Moonlighting must not interfere with the goals and objectives of the educa interfere with the resident's fitness fo safety. (Core)
VI.F.5.b)	Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)	6.25.a.	Time spent by residents in internal an in the ACGME Glossary of Terms) mu maximum weekly limit. (Core)
VI.F.5.c)	PGY-1 residents are not permitted to moonlight. (Core)	6.25.b.	PGY-1 residents are not permitted to
VI.F.6.	In-House Night Float Night float must occur within the context of the 80-hour and one-day-off-in- seven requirements. (Core)	6.26.	In-House Night Float Night float must occur within the cont seven requirements. (Core)
VI.F.6.a)	Night float rotations cannot exceed two consecutive months in duration, and residents can have no more than three months of night float assignments per year. (Core)	6.26.a.	Night float rotations cannot exceed two or residents can have no more than three n year. (Core)
VI.F.6.b)	There must be at least two months between each night float rotation. (Core)	6.26.b.	There must be at least two months betw
VI.F.7.	Maximum In-House On-Call Frequency Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)	6.27.	Maximum In-House On-Call Frequenc Residents must be scheduled for in-h every third night (when averaged ove

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

lucation must be counted toward the

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

logy – Head and Neck Surgery will not 80-hour limit to the residents' work

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

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

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

o moonlight. (Core)

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

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

ween each night float rotation. (Core)

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

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

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

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resident. (Core)