Request for Resident / Fellow Complement Change

Graduate Medical Education

1. **PROGRAM INFORMATION**

|  |  |
| --- | --- |
| **Program Name** | Click here to enter text. |
| **Program Director** | Click here to enter text. |
| **Accreditation/Approval** | [ ]  ACGME [ ]  TMB or GMEC [ ]  Other Accreditation |
| **Type of Request** *(i.e., Permanent or Temporary)* | [ ]  Permanent [ ]  Temporary (only 1 year or more) |
| If Temporary, duration of increase (in years) | Click here to enter text. |
| **Proposed Funding Source** | *Please include letter of financial support* |
|  |
| **Complement Change Request** |
| **PGY Level** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **Total** |
| **CURRENT** | X | X | X | X | X | X | X | X | X | X |
| **PROPOSED** | X | X | X | X | X | X | X | X | X | X |

1. **EDUCATIONAL PROGRAM INFORMATION**

|  |
| --- |
| **Provide an educational rationale for this increase**. The rationale must be educational in nature and not based on service demands. E.g., increased time for didactics, enhance the learning environment, improve the experience on certain rotations, new clinical experiences required by the accrediting agency, duty hour compliance, etc. It must justify the request in terms of institutional support, including funding. |
| Click here to enter text. |
| What other trainees rotate through this program (i.e., medical students, fellows from other programs, residents, international scholars)? What impact, if any, would this increase have on these trainees or on other HMH programs? |
| Click here to enter text. |
| Please provide an update on any major changes in the Program since the last academic year. |
| Click here to enter text. |
| Current Core Faculty to Trainee Ratio | Click here to enter text. |
| Proposed Core Faculty to Trainee Ratio, if increase is approved | Click here to enter text. |
| Describe other impacts, if any, this increase would have (e.g. on space/facilities, such as office space, computers, call space, etc.) |
| Click here to enter text. |
| Described the adequacy of current clinical volumes and does it support this increase? Please provide data. |
| Click here to enter text. |

1. **IMPLEMENTATION PLAN / TIMING**

**(Include projected start date, and PGY levels)**

***(Example: If complement request of three residents is requested and approved, one PGY-1 resident to begin on July 1, 2022, and an additional resident added each subsequent year)***

|  |
| --- |
| Click here to enter text. |

1. **ATTACHMENTS & APPROVALS**

**\*\*Note**: Attachments required for complement increase requests that are longer than 2 months. **\*\***

|  |
| --- |
|[ ]  Current Block Diagram  |
|[ ]  Proposed Block Diagram *(reflects complement increase request)* |
|[ ]  Letter of Financial Support with proposed funding source(s) |

|  |
| --- |
| ***NOTE:  If for a Fellowship Program, Signature must be obtained from BOTH the Fellowship Director AND the Core Program Director.*** |

 Signature Date

|  |  |  |
| --- | --- | --- |
| **Fellowship Director’s Signature** |  |  |
| **Core Program Director’s Signature** |  |  |
| **Department Chair’s Signature** |  |  |

**Scan and return the completed and signed form to the GME Office**.

Approved by GMEC (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_