**LETTER OF FINANCIAL SUPPORT FOR GME TRAINING PROGRAMS**

January 19, 2023

Attn: Graduate Medical Education Internal Review Committee,

GME Office, HMAI R2-201

**RE: Request for** Select new program or complement increase**: PROGRAM NAME**

Dear Committee Members,

Please accept this letter as confirmation that the **Department/Division of NAME** is in full support of this request for a **Select new program or complement increase**. and this request is submitted on behalf of the program director, Dr. **PROGRAM DIRECTOR NAME.**

***Describe brief educational rationale for request.***

***\*Complete table pertinent to your request. You may delete table that is unrelated.***

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NEW PROGRAM Request** | | | | | | | | | | | |
| **Anticipated program start date** |  | | | | | | | | | | |
|  | | | | | | | | | |  | |
| **PGY Level** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **TOTAL** |
| **Proposed Trainee Complement** |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **COMPLEMENT INCREASE Request** | | | | | | | | | | | |
|  | | | | | | | | | |  | |
| **PGY Level** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **TOTAL** |
| **Current Trainee Complement** |  |  |  |  |  |  |  |  |  |  |
| **Proposed Trainee Complement** |  |  |  |  |  |  |  |  |  |  |

The **Department/Division of NAME** will support the additional funding costs associated with the new training program or complement increase including, but not limited to, salary and fringe benefits, educational stipend in accordance to GME Procedure 35, Board Certifying exam cost, and Resident Fatigue Transportation Program. The source(s) for the funding are documented in the table below.

**Specify Source(s), Account Number(s) and Specific Revenue Source(s), and percentage covered by each source.** *\*percent covered must equal 100%*

| **Funding Sources**  *(grant, philanthropy, etc.)* | **Department Number** | **% Covered** |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **Total** |  |

Ongoing approval for this program is contingent upon continued availability of funding. Should the source of funding cease in the future, we understand that this approval may be rescinded. In this event, the department remains responsible to support individuals in the process of completing their training, in accordance with ACGME requirements.

Please contact **PROGRAM DIRECTOR NAME** for any additional information or details in support of this request at **PROGRAM DIRECTOR PHONE & EMAIL.**

Sincerely,

|  |  |  |
| --- | --- | --- |
| **(Signature, Department Chair)**  Department Chair Name |  | **(Signature, Program Director)**  Program Director Name |