## cid:48F8347D-90B0-4A99-B79D-DE332E9CE8DD@home9312 Old Georgetown Road

## Bethesda, Maryland 20814

## 301-581-9200

**PODIATRIC MEDICINE AND SURGERY RESIDENCY**

***PRE-EVALUATION REPORT***

The Council on Podiatric Medical Education and the Residency Review Committee require an institution seeking continuing approval of an established podiatric residency to submit this form along with supplemental materials regarding the educational program. This information will be reviewed by the evaluation team prior to the on-site visit.

**This form and supplemental materials must be submitted in PDF format, as a single, bookmarked, and continuous document**. **RRC and the Council require that the program’s director is the individual responsible for submitting all materials to Council staff related to all application, on-site evaluation, and approval processes.** Information submitted in multiple files will not be accepted and will be returned to the institution for resubmission.

|  |  |
| --- | --- |
| 1. **Sponsoring Institution Information** | |
| Sponsoring institution |  |
| Address 1 |  |
| Address 2 |  |
| City/State/Zip |  |
| Telephone |  |
| Website Address |  |

|  |  |
| --- | --- |
| 1. **Co-Sponsoring Institution Information (if applicable)** | |
| Co-sponsoring institution |  |
| Address 1 |  |
| Address 2 |  |
| City/State/Zip |  |
| Telephone |  |
| Website Address |  |

|  |  |
| --- | --- |
| 1. **Program Director Information** | |
| Name: |  |
| Office Address 1 |  |
| Office Address 2 |  |
| City/State/Zip |  |
| Telephone |  |
| Fax |  |
| Mobile Phone |  |
| Email |  |

|  |  |
| --- | --- |
| 1. **Administration – Sponsoring Institution (include professional degrees when applicable, e.g., DPM, MD, DO, etc.)** | |
| Chief Administrative Officer |  |
| Designated Institutional Official |  |
| Chief of Podiatric Staff |  |
| Chief of Medical Staff |  |
| Director of Graduate Medical Education |  |
| Chief of Surgical Staff |  |

|  |  |
| --- | --- |
| 1. **Administration – Co-sponsoring Institution (if applicable)** | |
| Chief Administrative Officer |  |
| Designated Institutional Official |  |
| Chief of Podiatric Staff |  |
| Chief of Medical Staff |  |
| Director of Graduate Medical Education |  |
| Chief of Surgical Staff |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Program Information** | | | |
|  | **Type of Program(s)** | **Length of Program(s)** | |
| Podiatric Medicine and Surgery Residency (PMSR) | 36 Months |  |
| Podiatric Medicine and Surgery Residency with Reconstructive Rearfoot/Ankle Surgery (PMSR/RRA) | 36 Months | 48 Months |
|  | Number of Approved Positions | PMSR //  PMSR/RRA /// | |
|  | Program start and end date (*e.g. July 1 – June 30*) |  | |
|  | Resident Stipend | $     , $     , $     , $ | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Residency Policies** | | YES | **NO** | **N/A** |
|  | The institution has identified a committee responsible for interviewing and selecting residents.  If yes, describe the composition of the committee: |  |  |  |
|  | Prospective residents are informed in writing of the selection process and conditions of appointment established for the program.  If no, please provide an explanation: |  |  |  |
|  | The institution makes available a written copy of the residency curriculum to the prospective resident.  If no, please provide an explanation: |  |  |  |
|  | Is the applicant charged a fee?  If yes, what is the amount?  To whom is the amount paid? |  |  |  |
|  | The sponsoring institution participates in a national resident application matching service.  If no, please provide an explanation: |  |  |  |
|  | On what date was the interview conducted? | | | |
|  | On what date did the sponsoring institution obtain a binding commitment from the prospective resident(s)? | | | |

**Supplemental Materials**

The following items must be submitted to CPME as requested in the initial on-site email. **Please refer to the referenced requirements in CPME 320, *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies,* for further information specific to each required document.**

A **Pre-Evaluation Report Cover Page** is provided at the end of this document to be submitted with the supplemental materials.

|  |
| --- |
| **1. Accreditation documents** |
| Provide copies of the accreditation document for the sponsoring institution and co-sponsoring institution (if applicable) ***(requirement 1.2)****.* |

| **2. Affiliated Training Sites**  Provide the following information for each affiliated training site (e.g., hospital, surgery center, private practice office). ***(requirement 1.3)***  **Supplemental material:**  For each institution identified below, provide copies of  **2a. Executed affiliation agreements** between the sponsoring institution and the affiliates, including a separate written confirmation of the appointment of the site coordinator (if this information is not on the agreement)  **2b.** A**ccreditation documents** (e.g. Joint Commission and AAAHC), if applicable, for affiliated training sites | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | **City, State** | **Accredited**  **By** | **Percentage**  **of Training** | **Date Affiliation Signed/**  **Effective Date** | **Coordinator** | |
| **Staff?** | **Name** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Standard 3 – Polices Affecting the Resident** | |
| 3a. | One copy of the resident contract or letter of appointment between the sponsoring institution(s) and residents and signature pages for each current resident in each year of training. ***(requirements 3.6 and 3.7)*** |
| 3b. | Residency manual that will be distributed at the beginning of the program to residents, faculty, and administrative staff involved in the residency. The manual must include at minimum the following components ***(requirement 3.9)***:  The mechanism of appeal  Performance improvement methods established to address instances of unsatisfactory resident performance  Resident clinical and educational work hours  The rules and regulations for the conduct of the resident  Transition of Care  Curriculum, including competencies and assessment documents specific to each rotation *(refer to requirements 6.1 and 6.4)*  Training schedule (*refer to requirement 6.3)*  Schedule of didactic activities and critical analysis of scientific literature *(refer to requirements 6.7 and 6.8)*  Policies and programs that encourage optimal resident well-being *(refer to requirement 3.13)*  CPME 320 and CPME 330 or links to these documents on the Council’s website |
| 3c. | Certificate to be awarded the resident upon completion of training. ***(requirement 3.10)*** |
| 3d. | Documentation to demonstrate that policies and programs are in place that encourage optimal resident well-being. If this information is in the residency manual, please provide reference to the pages in the manual where this information can be found. ***(requirement 3.13)*** |

| **Standard 5 – Program Director and Faculty** | |
| --- | --- |
| 5a. | Curriculum vitae of the program director and a statement providing evidence that the director possesses appropriate clinical, administrative, and teaching qualifications suitable for implementing the residency and is certified by at least one board recognized by the Specialty Board Recognition Committee (if appointed after July 2023) and has a minimum of three years of post-residency clinical experience. ***(requirement 5.2)*** |
| 5b. | List of podiatric medical faculty actively involved in the program with educational and professional qualifications of each. For each staff member, list only name, degree, and affiliations with certifying and professional organizations (e.g. ABPM and ABFAS). Additionally, identify which podiatric faculty are affiliated with other CPME–approved residency programs. ***(requirements 5.5 and 5.6)*** |
| 5c. | List of non-podiatric medical faculty actively involved in the program with educational and professional qualifications of each. For each staff member, list only name, degree (MD, DO, PhD, RN, etc.), and affiliations with certifying and professional organizations. ***(requirements 5.5 and 5.6)*** |

|  |  |
| --- | --- |
| **Standard 7 – Program and Resident Assessment** | |
| 7a. | Copies of completed assessment documents for all rotations for each resident from the start of his/her training. Assessment documents must identify the rotation and duration (e.g. August 1 – August 15, 2015) and include the dates and signatures of the faculty, resident, and program director. ***(requirement 7.2a)*** |
| 7b. | Copies of documents demonstrating that the program meets with each resident on a semi-annual basis to review the extent to which the residents are achieving the competencies. ***(requirement 7.2b)*** |
| 7c. | Copies of documents demonstrating that the program director conducts a final assessment of the resident prior to completion of the program. ***(requirement 7.2c)*** |

|  |  |
| --- | --- |
| 7d | Description and copy of the most recent completed annual self-assessment of the program’s resources and curriculum. ***(requirement 7.4)*** |

|  |  |
| --- | --- |
| **Miscellaneous Information** | |
| 8. | Copy of the ACLS certificate for each resident ***(requirement 6.5)*** | |
| 9 | List with each resident’s name, the resident’s year of training, residency category (if the program sponsors both a PMSR and PMSR/RRA) and e-mail address. | |

***Because the institution must utilize an electronic logging system, the on-site evaluation team will review resident logs online.***

By signing this form, the chief administrative officer(s) and the program director confirm the commitment of the institution(s) in providing podiatric residency training.

Chief administrative officer (or DIO) Date

Chief administrative officer of co–sponsoring institution (if applicable) Date

Program director Date

**Chart of Rotations**

Requirement 6.4

**The program director must submit this rotation chart as part of the pre-evaluation material. The team will confirm this information with the training schedule provided in the resident manual.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Rotation** | **Offered**  (Only indicate if YES) | **Format**  (block or sequential) | **Length** | **Location** |
| **Required Rotations – minimum of two weeks unless otherwise noted** | | | | |
| Anesthesiology |  |  |  |  |
| Behavioral Sciences |  |  |  |  |
| Emergency Medicine *(min 4 weeks)* |  |  |  |  |
| Medical Imaging |  |  |  |  |
| **Medical Specialty Rotations - minimum requirement of 12 cumulative weeks of training in medical specialties** | | | | |
| Internal Medicine/Family Practice  *(min 4 weeks)* |  |  |  |  |
| Infectious disease |  |  |  |  |
| **Medical Subspecialty Rotations (training must include at least two)** | | | | |
| Burn Unit |  |  |  |  |
| Dermatology |  |  |  |  |
| Endocrinology |  |  |  |  |
| Geriatrics |  |  |  |  |
| Intensive/Critical Care |  |  |  |  |
| Neurology |  |  |  |  |
| Pain Management |  |  |  |  |
| Pediatrics |  |  |  |  |
| Physical Medicine and Rehabilitation |  |  |  |  |
| Rheumatology |  |  |  |  |
| Wound Care |  |  |  |  |
| Vascular Medicine |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Rotation** | **Offered**  (Only indicate if YES) | **Format**  (block or sequential) | **Length** | **Location** | | |
| **Surgical Specialty Rotations –**  **Minimum requirement of 8 cumulative weeks**  **Training must include at least two of the following rotations** | | | | | | |
| Endovascular/Vascular *(min 2 weeks)* |  |  |  |  | | |
| Cardiothoracic surgery |  |  |  |  | | |
| General surgery |  |  |  |  | | |
| Hand surgery |  |  |  |  | | |
| Orthopedic surgery |  |  |  |  | | |
| Neurosurgery |  |  |  |  | | |
| Orthopedic/surgical oncology |  |  |  |  | | |
| Pediatric orthopedic surgery |  |  |  |  | | |
| Plastic surgery |  |  |  |  | | |
| Surgical intensive care unit (SICU) |  |  |  |  | | |
| Trauma team/surgery |  |  |  |  | | |
| **Other rotations:** | | | | | | |
|  |  |  |  |  | | |
|  |  |  |  |  | | |
|  |  |  |  |  | | |
|  |  |  |  |  | | |
|  |  |  |  |  | | |
| **Time spent in the Medical Specialty rotations must equal 12 cumulative weeks of training** | | | | | **YES** | **NO** |
|  |  |
| **Time spent in the Surgical Specialty rotations must equal 8 cumulative weeks of training** | | | | | **YES** | **NO** |
|  |  |
|  |  |

**Pre-Evaluation Report**

**Supplemental Material Cover Page**

|  |  |
| --- | --- |
| **Program Name** |  |
| **Program Director** |  |

**Contents of this File:**

|  |  |  |
| --- | --- | --- |
| **Item #** | **Material Requested** | **Page** |
| 1. | Accreditation document for sponsoring institution(s)  *Requirement 1.2* |  |
| 2a. | Affiliation agreements and written confirmation of the appointment of a site coordinator  *Requirement 1.3* |  |
| 2b. | Accreditation documents of affiliated facilities  *Requirement t 1.3* |  |
| 3a. | Resident contracts – Letter of Appointment  *Requirements 3.8 and 3.9* |  |
| 3b. | Residency manual  *Requirement 3.9* |  |
| 3c. | Certificate of completion of residency  *Requirement 3.10* |  |
| 3d. | Documentation to demonstrate that policies and programs are in place that encourage optimal resident well-being  *Requirement 3.13* |  |
| 5a. | Curriculum Vitae of program director and statement of qualifications  *Requirement 5.2* |  |
| 5b. | List of podiatric faculty  *Requirements 5.5 and 5.6* |  |
| 5c. | List of non-podiatry faculty  *Requirements 5.5 and 5.6* |  |
| 7a. | Assessment of all Rotations of each Resident  *Requirement 7.2a*  These may be uploaded as a separate file if necessary |  |
| 7b. | Semi-Annual Resident Assessment  *Requirement 7.2b* |  |
| 7c. | Final assessment of the resident  *Requirement 7.2c* |  |
| 7d. | Program annual self-assessment  *Requirement 7.4* |  |
| 8. | Copies of ACLS Certificates for each resident  *Requirement 6.5* |  |
| 9. | List of Residents |  |

*Please bookmark the PDF document and title each section with the labels listed above*