Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.A.	***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 years later.***	[None]	**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 years later.***
Int.A. (Continued)	***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 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 members of the health care team.***	[None] - (Continued)	***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 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 members of the health care team.***

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.B.	**Definition of Specialty** Residencies in emergency medicine prepare physicians for the practice of emergency medicine. These programs must teach the fundamental skills, knowledge, and humanistic qualities that constitute the foundations of emergency medicine practice. These programs provide progressive responsibility for and experience in these areas to enable effective management of clinical problems. Residents must have the opportunity, under the guidance and supervision of a qualified faculty member, to develop a satisfactory level of clinical maturity, judgment, and technical skill. On completion of the program, residents should be capable of practicing emergency medicine, able to incorporate new skills and knowledge during their careers, and able to monitor their own physical and mental well-being.	**[None]**	**Definition of Specialty** *Residencies in emergency medicine prepare physicians for the practice of emergency medicine. These programs must teach the fundamental skills, knowledge, and humanistic qualities that constitute the foundations of emergency medicine practice. These programs provide progressive responsibility for and experience in these areas to enable effective management of clinical problems. Residents must have the opportunity, under the guidance and supervision of a qualified faculty member, to develop a satisfactory level of clinical maturity, judgment, and technical skill. On completion of the program, residents should be capable of practicing emergency medicine, able to incorporate new skills and knowledge during their careers, and able to monitor their own physical and mental well-being.*
Int.C.	**Length of Educational Program** Residency programs in emergency medicine are configured in 36-month and 48-month formats, and must include a minimum of 36 months of clinical education. (Core)	**4.1.**	**Length of Program** Residency programs in emergency medicine are configured in 36-month and 48-month formats, and must include a minimum of 36 months of clinical education. (Core)
Int.C.1.	Programs utilizing the 48-month format must ensure that all of the clinical, educational, and milestone elements contained in these Program Requirements are met, and must provide additional in-depth experience in areas related to emergency medicine, such as medical education, clinical- or laboratory-based research, or global health. An educational justification describing the additional educational goals and outcomes to be achieved by residents in the incremental 12 months of education must be submitted to the Review Committee prior to implementation, and at each subsequent accreditation review of residency programs of 48 months' duration. (Core)	4.1.a.	Programs utilizing the 48-month format must ensure that all of the clinical, educational, and milestone elements contained in these Program Requirements are met, and must provide additional in-depth experience in areas related to emergency medicine, such as medical education, clinical- or laboratory-based research, or global health. An educational justification describing the additional educational goals and outcomes to be achieved by residents in the incremental 12 months of education must be submitted to the Review Committee prior to implementation, and at each subsequent accreditation review of residency programs of 48 months' duration. (Core)
I.	**Oversight**	**Section 1**	**Section 1: Oversight**
I.A.	**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.*** ***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]**	**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.*** ***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.***
I.A.1.	**The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**	**1.1.**	**The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**
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 providing educational experiences or educational assignments/rotations for residents.***

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 Sponsoring Institution, must designate a primary clinical site. (Core)**
I.B.2.	**There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**	**1.3.**	**There must be a program letter of 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)**
I.B.2.a)	**The PLA must:**	**[None]**	
I.B.2.a).(1)	**be renewed at least every 10 years; and, (Core)**	**1.3.a.**	**The PLA must be renewed at least every 10 years. (Core)**
I.B.2.a).(2)	**be approved by the designated institutional official (DIO). (Core)**	**1.3.b.**	**The PLA must be approved by the designated institutional official (DIO). (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 clinical learning and working environment 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 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)**
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 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)**
I.B.4.a)	The program should be based at the primary clinical site. (Core)	1.6.a.	The program should be based at the primary clinical site. (Core)
I.B.4.b)	Programs using multiple participating sites must ensure the provision of a unified educational experience for the residents. (Core)	1.6.b.	Programs using multiple participating sites must ensure the provision of a unified educational experience for the residents. (Core)
I.B.4.b).(1)	Each participating site must offer significant educational opportunities to the overall program. (Core)	1.6.c.	Each participating site must offer significant educational opportunities to the overall program. (Core)
I.B.4.c)	Required rotations to participating sites that are geographically distant from the sponsoring institution must offer educational opportunities unavailable locally that significantly augment residents' overall educational experience. (Core)	1.6.d.	Required rotations to participating sites that are geographically distant from the sponsoring institution must offer educational opportunities unavailable locally that significantly augment residents' overall educational experience. (Core)
I.B.4.c).(1)	The program should ensure that residents are not unduly burdened by required rotations at geographically distant sites. (Core)	1.6.e.	The program should ensure that residents are not unduly burdened by required rotations at geographically distant sites. (Core)
I.C.	**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 present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)**	**1.7.**	**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 present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)**
I.D.	**Resources**	**1.8.**	**Resources** **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)**
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 Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)**
I.D.1.a)	The program must demonstrate the availability of educational resources, including the presence of residents in other specialties, to enhance the training of the emergency medicine residents. (Core)	1.8.a.	The program must demonstrate the availability of educational resources, including the presence of residents in other specialties, to enhance the training of the emergency medicine residents. (Core)
I.D.1.b)	At every site in which the emergency department provides resident education, the following must be provided: (Core)	1.8.b.	At every site in which the emergency department provides resident education, the following must be provided: (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
I.D.1.b).(1)	adequate space for patient care; (Core)	1.8.b.1.	adequate space for patient care; (Core)
I.D.1.b).(2)	space for clinical support services; (Core)	1.8.b.2.	space for clinical support services; (Core)
I.D.1.b).(3)	diagnostic imaging completed and results available on a timely basis, especially those required on a STAT basis; (Core)	1.8.b.3.	diagnostic imaging completed and results available on a timely basis, especially those required on a STAT basis; (Core)
I.D.1.b).(4)	laboratory studies completed and results available on a timely basis, especially those required on a STAT basis; (Core)	1.8.b.4.	laboratory studies completed and results available on a timely basis, especially those required on a STAT basis; (Core)
I.D.1.b).(5)	office space for core physician faculty members, and residents; (Core)	1.8.b.5.	office space for core physician faculty members, and residents; (Core)
I.D.1.b).(6)	instructional space; (Core)	1.8.b.6.	instructional space; (Core)
I.D.1.b).(7)	information systems; and, (Core)	1.8.b.7.	information systems; and, (Core)
I.D.1.b).(8)	appropriate security services and systems to ensure a safe working environment. (Core)	1.8.b.8.	appropriate security services and systems to ensure a safe working environment. (Core)
I.D.1.c)	Clinical support services must include nursing, clerical, intravenous, electrocardiogram (EKG), respiratory therapy, transporter, and phlebotomy, and must be available on a 24-hour basis so that residents are not burdened with these duties. (Core)	1.8.c.	Clinical support services must include nursing, clerical, intravenous, electrocardiogram (EKG), respiratory therapy, transporter, and phlebotomy, and must be available on a 24-hour basis so that residents are not burdened with these duties. (Core)
I.D.1.d)	Office space for program coordinators and additional support personnel must be provided at the primary clinical site. (Core)	1.8.d.	Office space for program coordinators and additional support personnel must be provided at the primary clinical site. (Core)
I.D.1.e)	Each clinical site must provide timely consultation from services based on a patient's acuity. (Core)	1.8.e.	Each clinical site must provide timely consultation from services based on a patient's acuity. (Core)
I.D.1.e).(1)	If any clinical services are not available for consultation or admission, each clinical site must have a written protocol for provision of these services elsewhere. (Core)	1.8.e.1.	If any clinical services are not available for consultation or admission, each clinical site must have a written protocol for provision of these services elsewhere. (Core)
I.D.1.e).(2)	Each clinical site must ensure timely consultation decisions by a provider from admitting and consulting services with decision making authority. (Core)	1.8.e.2.	Each clinical site must ensure timely consultation decisions by a provider from admitting and consulting services with decision making authority. (Core)
I.D.1.f)	The patient population must include patients of all ages and genders as well as patients with a wide variety of clinical problems. (Core)	1.8.f.	The patient population must include patients of all ages and genders as well as patients with a wide variety of clinical problems. (Core)
I.D.1.g)	The primary clinical site to which residents rotate must have at least 30,000 emergency department visits annually. (Core)	1.8.g.	The primary clinical site to which residents rotate must have at least 30,000 emergency department visits annually. (Core)
I.D.1.g).(1)	The primary clinical site should have a significant number of critically ill or critically injured patients constituting at least three percent or 1200 (whichever is greater) of the emergency department patients per year. (Core)	1.8.g.1.	The primary clinical site should have a significant number of critically ill or critically injured patients constituting at least three percent or 1200 (whichever is greater) of the emergency department patients per year. (Core)
I.D.1.g).(2)	All other emergency departments to which residents rotate for four months or longer should each have at least 30,000 emergency department visits annually. (Core)	1.8.g.2.	All other emergency departments to which residents rotate for four months or longer should each have at least 30,000 emergency department visits annually. (Core)
I.D.1.h)	Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians. (Core)	1.8.h.	Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians. (Core)
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 Sponsoring Institution, must ensure healthy and safe learning and working environments that promote 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/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)**
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 that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**
I.D.2.d)	**security and safety measures appropriate to the participating site; and, (Core)**	**1.9.d.**	**security and safety measures appropriate to the participating site; and, (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
I.D.2.e)	accommodations for residents with disabilities consistent with the Sponsoring Institution’s policy. (Core)	1.9.e.	accommodations for residents with disabilities consistent with the 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 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)
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 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)
II.	Personnel	Section 2	Section 2: Personnel
II.A.	Program Director	2.1.	Program Director 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)
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 appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)
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 must approve a change in program director and must verify the program director’s licensure and clinical appointment. (Core)
II.A.1.a).(1)	Final approval of the program director resides with the Review Committee. (Core)	2.2.a.	Final approval of the program director resides with the Review Committee. (Core)
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 retention of the program director for a length of time adequate to maintain continuity of leadership and program 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 applicable, the program’s leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

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II.A.2.a)	The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core) Number of Approved Resident Positions:18-20 | Minimum Support Required (FTE): 0.6 | Assistant or Associate Program Directors: 1 Number of Approved Resident Positions:21-25 | Minimum Support Required (FTE): 0.7 | Assistant or Associate Program Directors: 1 Number of Approved Resident Positions:26-30 | Minimum Support Required (FTE): 0.8 | Assistant or Associate Program Directors: 1 Number of Approved Resident Positions:31-35 | Minimum Support Required (FTE): 0.85 | Assistant or Associate Program Directors: 1 Number of Approved Resident Positions:36-40 | Minimum Support Required (FTE): 1 | Assistant or Associate Program Directors: 2 Number of Approved Resident Positions:41-45 | Minimum Support Required (FTE): 1.1 | Assistant or Associate Program Directors: 2 Number of Approved Resident Positions:46-50 | Minimum Support Required (FTE): 1.2 | Assistant or Associate Program Directors: 2 Number of Approved Resident Positions:51-53 | Minimum Support Required (FTE): 1.2 | Assistant or Associate Program Directors: 2	2.4.a.	The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core) Number of Approved Resident Positions:18-20 | Minimum Support Required (FTE): 0.6 | Assistant or Associate Program Directors: 1 Number of Approved Resident Positions:21-25 | Minimum Support Required (FTE): 0.7 | Assistant or Associate Program Directors: 1 Number of Approved Resident Positions:26-30 | Minimum Support Required (FTE): 0.8 | Assistant or Associate Program Directors: 1 Number of Approved Resident Positions:31-35 | Minimum Support Required (FTE): 0.85 | Assistant or Associate Program Directors: 1 Number of Approved Resident Positions:36-40 | Minimum Support Required (FTE): 1 | Assistant or Associate Program Directors: 2 Number of Approved Resident Positions:41-45 | Minimum Support Required (FTE): 1.1 | Assistant or Associate Program Directors: 2 Number of Approved Resident Positions:46-50 | Minimum Support Required (FTE): 1.2 | Assistant or Associate Program Directors: 2 Number of Approved Resident Positions:51-53 | Minimum Support Required (FTE): 1.2 | Assistant or Associate Program Directors: 2

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.A.2.a) - (Continued)	Number of Approved Resident Positions:54-55 | Minimum Support Required (FTE): 1.3 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:56-60 | Minimum Support Required (FTE): 1.4 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:61-65 | Minimum Support Required (FTE): 1.5 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:66-70 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:71-75 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:76-80 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:81-85 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:86-90 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:91-95 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:96-100 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3	2.4.a. - (Continued)	Number of Approved Resident Positions:54-55 | Minimum Support Required (FTE): 1.3 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:56-60 | Minimum Support Required (FTE): 1.4 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:61-65 | Minimum Support Required (FTE): 1.5 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:66-70 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:71-75 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:76-80 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:81-85 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:86-90 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:91-95 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3 Number of Approved Resident Positions:96-100 | Minimum Support Required (FTE): 1.55 | Assistant or Associate Program Directors: 3
II.A.2.b)	From the support table listed above, program directors of programs approved for 18-35 residents must be provided no less than 35 percent support and program directors of programs approved for 36 or more residents must be provided no less than 50 percent support. (Core)	2.4.b.	From the support table listed above, program directors of programs approved for 18-35 residents must be provided no less than 35 percent support and program directors of programs approved for 36 or more residents must be provided no less than 50 percent support. (Core)
II.A.3.	**Qualifications of the program director:**	**2.5.**	**Qualifications of the Program Director** **The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)**
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 Director** **The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)**
II.A.3.b)	**must include current certification in the specialty for which they are the program director by the American Board of** Emergency Medicine (ABEM) **or by the American Osteopathic Board of** Emergency Medicine (AOBEM), **or specialty qualifications that are acceptable to the Review Committee; and, (Core)**	**2.5.a.**	**The program director must possess current certification in the specialty for which they are the program director by the American Board of** Emergency Medicine (ABEM) **or by the American Osteopathic Board of** Emergency Medicine (AOBEM), **or specialty qualifications that are acceptable to the Review Committee. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.A.3.b).(1)	The Review Committee for Emergency Medicine will only consider ABMS and AOA board certification as acceptable program director certification qualifications. (Core)	2.5.a.1.	The Review Committee for Emergency Medicine will only consider ABMS and AOA board certification as acceptable program director certification qualifications. (Core)
II.A.3.c)	**must include ongoing clinical activity. (Core)**	**2.5.b.**	**The program director must demonstrate ongoing clinical activity. (Core)**
II.A.3.d)	must be a core physician faculty member; (Core)	2.5.c.	The program director must be a core physician faculty member. (Core)
II.A.3.e)	must include demonstrated experience in a leadership role; and, (Core)	2.5.d.	The program director must have demonstrated experience in a leadership role. (Core)
II.A.3.f)	must include evidence of ongoing involvement in scholarly activity, including peer-reviewed publications. (Core)	2.5.e.	The program director must include evidence of ongoing involvement in scholarly activity, including peer-reviewed publications. (Core)
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 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)**
II.A.4.a)	**The program director must:**	**[None]**	
II.A.4.a).(1)	**be a role model of professionalism; (Core)**	**2.6.a.**	**The program director must be a role model of professionalism. (Core)**
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 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)**
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 administer and maintain a learning environment conducive to educating the residents in each of the ACGME 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 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)**
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 authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)**
II.A.4.a).(6)	**submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**	**2.6.f.**	**The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)**
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 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)**
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 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)**
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 program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 sign a non-competition guarantee or restrictive covenant. (Core)
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 verification of education for all residents within 30 days of completion of or departure from the program. (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 verification of an individual resident's education upon the resident's request, within 30 days. (Core)
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.l.	The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)
II.B.	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 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 *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 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.*
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.2.	Faculty members must:	[None]	
II.B.2.a)	be role models of professionalism; (Core)	2.8.	Faculty Responsibilities 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, equitable, high-quality, cost-effective, patient-centered care. (Core)
II.B.2.c)	demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)	2.8.b.	Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. (Core)
II.B.2.d)	administer and maintain an educational environment conducive to educating residents; (Core)	2.8.c.	Faculty members must administer and maintain an educational environment conducive to educating residents. (Core)
II.B.2.e)	regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)	2.8.d.	Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.B.2.f)	**pursue faculty development designed to enhance their skills at least annually: (Core)**	**2.8.e.**	**Faculty members must pursue faculty development designed to enhance 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.g)	Faculty members supervising emergency medicine residents in an adult emergency department must either be ABEM/AOBEM board-eligible or have current ABEM and/or AOBEM certification in emergency medicine. (Core)	2.8.f.	Faculty members supervising emergency medicine residents in an adult emergency department must either be ABEM/AOBEM board-eligible or have current ABEM and/or AOBEM certification in emergency medicine. (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.a).(1)	Faculty members supervising emergency medicine residents on pediatric emergency medicine rotations where pediatric emergency medicine fellows are also present must be certified in pediatrics, emergency medicine, or pediatric emergency medicine by the ABEM, American Board of Pediatrics, AOBEM, or American Osteopathic Board of Pediatrics. (Core)	2.9.a.	Faculty members supervising emergency medicine residents on pediatric emergency medicine rotations where pediatric emergency medicine fellows are also present must be certified in pediatrics, emergency medicine, or pediatric emergency medicine by the ABEM, American Board of Pediatrics, AOBEM, or American Osteopathic Board of Pediatrics. (Core)
II.B.3.a).(1).(a)	Faculty members board-certified solely in pediatrics may not supervise emergency medicine residents in the emergency department in all other settings. (Core)	2.9.a.1.	Faculty members board-certified solely in pediatrics may not supervise emergency medicine residents in the emergency department in all other settings. (Core)
II.B.3.b)	**Physician faculty members must:**	**[None]**	
II.B.3.b).(1)	**have current certification in the specialty by the American Board of** Emergency Medicine **or the American Osteopathic Board of** Emergency Medicine, **or possess qualifications judged acceptable to the Review Committee; or, (Core)**	**2.10.**	**Physician faculty members must have current certification in the specialty by the American Board of** Emergency Medicine **or the American Osteopathic Board of** Emergency Medicine**, or possess qualifications judged acceptable to the Review Committee. (Core)**
II.B.3.b).(2)	have certification by a subspecialty board sponsored or co-sponsored by the ABEM or the AOBEM. (Core)	2.10.a.	In lieu of the qualifications in 2.10., physician faculty members must have certification by a subspecialty board sponsored or co-sponsored by either the ABEM or the AOBEM. (Core)
II.B.4.	**Core Faculty** **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 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)**
II.B.4.a)	**Core faculty members must complete the annual ACGME Faculty Survey. (Core)**	**2.11.a.**	**Core faculty members must complete the annual ACGME Faculty Survey. (Core)**
II.B.4.b)	There must be a minimum of one core physician faculty member for every three residents in the program. (Core)	2.11.b.	There must be a minimum of one core physician faculty member for every three residents in the program. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.B.4.c)	At a minimum, each required core faculty member, excluding program leadership, must be provided with support equal to a dedicated minimum of 10 percent FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)	2.11.c.	At a minimum, each required core faculty member, excluding program leadership, must be provided with support equal to a dedicated minimum of 10 percent FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)
II.B.5.	Assistant or associate program directors must be clinically active in emergency medicine. (Core)	2.11.d.	Assistant or associate program directors must be clinically active in emergency medicine. (Core)
II.B.5.a)	Assistant or associate program directors must be core faculty members. (Core)	2.11.e.	Assistant or associate program directors must be core faculty members. (Core)
II.C.	**Program Coordinator**	**2.12.**	**Program Coordinator** **There must be a program coordinator. (Core)**
II.C.1.	**There must be a program coordinator. (Core)**	**2.12.**	**Program Coordinator** **There must be a program coordinator. (Core)**
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 provided with dedicated time and support adequate for administration of the program based upon its size 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: 18-20 | Minimum Support Required (FTE): 0.9 Number of Approved Resident Positions: 21-25 | Minimum Support Required (FTE): 1.0 Number of Approved Resident Positions: 26-30 | Minimum Support Required (FTE): 1.10 Number of Approved Resident Positions: 31-35 | Minimum Support Required (FTE): 1.20 Number of Approved Resident Positions: 36-40 | Minimum Support Required (FTE): 1.30	2.12.b.	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: 18-20 | Minimum Support Required (FTE): 0.9 Number of Approved Resident Positions: 21-25 | Minimum Support Required (FTE): 1.0 Number of Approved Resident Positions: 26-30 | Minimum Support Required (FTE): 1.10 Number of Approved Resident Positions: 31-35 | Minimum Support Required (FTE): 1.20 Number of Approved Resident Positions: 36-40 | Minimum Support Required (FTE): 1.30

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.C.2.a) - (Continued)	Number of Approved Resident Positions: 41-45 | Minimum Support Required (FTE): 1.40 Number of Approved Resident Positions: 46-50 | Minimum Support Required (FTE): 1.50 Number of Approved Resident Positions: 51-55 | Minimum Support Required (FTE): 1.60 Number of Approved Resident Positions: 56-60 | Minimum Support Required (FTE): 1.70 Number of Approved Resident Positions: 61-65 | Minimum Support Required (FTE): 1.80 Number of Approved Resident Positions: 66-70 | Minimum Support Required (FTE): 1.90 Number of Approved Resident Positions: 71-75 | Minimum Support Required (FTE): 2.0 Number of Approved Resident Positions: 76-80 | Minimum Support Required (FTE): 2.10 Number of Approved Resident Positions: 81-85 | Minimum Support Required (FTE): 2.20 Number of Approved Resident Positions: 86-90 | Minimum Support Required (FTE): 2.30 Number of Approved Resident Positions: 91-95 | Minimum Support Required (FTE): 2.40 Number of Approved Resident Positions: 96-100 | Minimum Support Required (FTE): 2.50	2.12.b. - (Continued)	Number of Approved Resident Positions: 41-45 | Minimum Support Required (FTE): 1.40 Number of Approved Resident Positions: 46-50 | Minimum Support Required (FTE): 1.50 Number of Approved Resident Positions: 51-55 | Minimum Support Required (FTE): 1.60 Number of Approved Resident Positions: 56-60 | Minimum Support Required (FTE): 1.70 Number of Approved Resident Positions: 61-65 | Minimum Support Required (FTE): 1.80 Number of Approved Resident Positions: 66-70 | Minimum Support Required (FTE): 1.90 Number of Approved Resident Positions: 71-75 | Minimum Support Required (FTE): 2.0 Number of Approved Resident Positions: 76-80 | Minimum Support Required (FTE): 2.10 Number of Approved Resident Positions: 81-85 | Minimum Support Required (FTE): 2.20 Number of Approved Resident Positions: 86-90 | Minimum Support Required (FTE): 2.30 Number of Approved Resident Positions: 91-95 | Minimum Support Required (FTE): 2.40 Number of Approved Resident Positions: 96-100 | Minimum Support Required (FTE): 2.50
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 Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)**
III.	**Resident Appointments**	**Section 3**	**Section 3: Resident Appointments**
III.A.	**Eligibility Requirements**	**3.2.**	**Eligibility Requirements** **An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)**
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 following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)**
III.A.1.a)	**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 Accreditation (AOACOCA); or, (Core)**	**3.2.a.**	**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 Accreditation (AOACOCA); or, (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
III.A.1.b)	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)	3.2.b.	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) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (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.	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) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (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.	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) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)
III.A.2.	[illegible] 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. (Core)	3.3.	[illegible] 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. (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)
III.B.	Resident Complement The program director must not appoint more residents than approved by the Review Committee. (Core)	3.4.	Resident Complement The program director must not appoint more residents than approved by the Review Committee. (Core)
III.B.1.	There should be a total of at least 18 residents in the program. (Core)	3.4.a.	There should be a total of at least 18 residents in the program. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
III.C.	**Resident Transfers** **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 of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)**
III.C.1.	For information concerning the transfer of residents between emergency medicine residencies with differing educational formats and advanced placement credit for education in other specialties, contact the ABEM and/or the AOBEM prior to the resident entering the program.	3.5.a.	For information concerning the transfer of residents between emergency medicine residencies with differing educational formats and advanced placement credit for education in other specialties, contact the ABEM and/or the AOBEM prior to the resident entering the program.
IV.	**Educational Program** ***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*** ***The 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 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	**Section 4: Educational Program** ***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*** ***The 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 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.***
IV.A.	**Educational Components** **The curriculum must contain the following educational components:**	4.2.	**Educational Components** **The curriculum must contain the following educational components:**
IV.A.1.	**a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)**	4.2.a.	**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)**
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 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)**
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 responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)**
IV.A.4.	**a broad range of structured didactic activities; and, (Core)**	4.2.d.	**a broad range of structured didactic activities; and, (Core)**
IV.A.4.a)	**Residents must be provided with protected time to participate in core didactic activities. (Core)**	4.11.	**Didactic and Clinical Experiences** **Residents must be provided with protected time to participate in core 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 promote patient safety-related goals, tools, and techniques. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.B.	**ACGME Competencies**	**[None]**	**ACGME Competencies** ***The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.***
IV.B.1.	**The program must integrate the following ACGME Competencies into the curriculum:**	**[None]**	**The program must integrate all ACGME Competencies into the curriculum.**
IV.B.1.a)	**Professionalism** **Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)**	**4.3.**	**ACGME Competencies – Professionalism** **Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)** **Residents must demonstrate competence in:**
IV.B.1.a).(1)	**Residents must demonstrate competence in:**	**4.3.**	**ACGME Competencies – Professionalism** **Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)** **Residents must demonstrate competence in:**
IV.B.1.a).(1).(a)	**compassion, integrity, and respect for others; (Core)**	**4.3.a.**	**compassion, integrity, and respect for others; (Core)**
IV.B.1.a).(1).(b)	**responsiveness to patient needs that supersedes self-interest; (Core)**	**4.3.b.**	**responsiveness to patient needs that supersedes self-interest; (Core)**
IV.B.1.a).(1).(c)	**cultural humility; (Core)**	**4.3.c.**	**cultural humility; (Core)**
IV.B.1.a).(1).(d)	**respect for patient privacy and autonomy; (Core)**	**4.3.d.**	**respect for patient privacy and autonomy; (Core)**
IV.B.1.a).(1).(e)	**accountability to patients, society, and the profession; (Core)**	**4.3.e.**	**accountability to patients, society, and the profession; (Core)**
IV.B.1.a).(1).(f)	**respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)**	**4.3.f.**	**respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)**
IV.B.1.a).(1).(g)	**ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**	**4.3.g.**	**ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**
IV.B.1.a).(1).(h)	**appropriately disclosing and addressing conflict or duality of interest. (Core)**	**4.3.h.**	**appropriately disclosing and addressing conflict or duality of interest. (Core)**
IV.B.1.b)	**Patient Care and Procedural Skills**	**[None]**	
IV.B.1.b).(1)	**Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**	**4.4.**	**ACGME Competencies – Patient Care and Procedural Skills (Part A)** **Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**
IV.B.1.b).(1).(a)	Residents must demonstrate competence in:	[None]	
IV.B.1.b).(1).(a).(i)	synthesizing essential data necessary for the correct management of a patient with multiple chronic medical problems and, when appropriate, comparing with a prior medical record and identifying significant differences between the current presentation and past presentations; (Core)	4.4.a.	Residents must demonstrate competence in synthesizing essential data necessary for the correct management of a patient with multiple chronic medical problems and, when appropriate, comparing with a prior medical record and identifying significant differences between the current presentation and past presentations. (Core)
IV.B.1.b).(1).(a).(ii)	generating an appropriate differential diagnosis; (Core)	4.4.b.	Residents must demonstrate competence in generating an appropriate differential diagnosis. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.B.1.b).(1).(a).(iii)	applying the results of diagnostic testing based on the probability of disease and the likelihood of test results altering management; (Core)	4.4.c.	Residents must demonstrate competence in applying the results of diagnostic testing based on the probability of disease and the likelihood of test results altering management. (Core)
IV.B.1.b).(1).(a).(iv)	narrowing and prioritizing the list of weighted differential diagnoses to determine appropriate management based on all of the available data; (Core)	4.4.d.	Residents must demonstrate competence in narrowing and prioritizing the list of weighted differential diagnoses to determine appropriate management based on all of the available data. (Core)
IV.B.1.b).(1).(a).(v)	implementing an effective patient management plan; (Core)	4.4.e.	Residents must demonstrate competence in implementing an effective patient management plan. (Core)
IV.B.1.b).(1).(a).(vi)	selecting and prescribing appropriate pharmaceutical agents based upon relevant considerations, such as: allergies; clinical guidelines; intended effect; financial considerations; institutional policies; mechanism of action; patient preferences; possible adverse effects; and potential drug-food and drug-drug interactions; and effectively combining agents and monitoring and intervening in the advent of adverse effects in the emergency department; (Core)	4.4.f.	Residents must demonstrate competence in selecting and prescribing appropriate pharmaceutical agents based upon relevant considerations, such as: allergies; clinical guidelines; intended effect; financial considerations; institutional policies; mechanism of action; patient preferences; possible adverse effects; and potential drug-food and drug-drug interactions; and effectively combining agents and monitoring and intervening in the advent of adverse effects in the emergency department. (Core)
IV.B.1.b).(1).(a).(vii)	progressing along a continuum of managing a single patient, to managing multiple patients and resources within the emergency department; (Core)	4.4.g.	Residents must demonstrate competence in progressing along a continuum of managing a single patient, to managing multiple patients and resources within the emergency department. (Core)
IV.B.1.b).(1).(a).(viii)	providing health care services aimed at preventing health problems or maintaining health; (Core)	4.4.h.	Residents must demonstrate competence in providing health care services aimed at preventing health problems or maintaining health. (Core)
IV.B.1.b).(1).(a).(ix)	working with health care professionals to provide patient-focused care; (Core)	4.4.i.	Residents must demonstrate competence in working with health care professionals to provide patient-focused care. (Core)
IV.B.1.b).(1).(a).(x)	identifying life-threatening conditions and the most likely diagnosis, synthesizing acquired patient data, and identifying how and when to access current medical information; (Core)	4.4.j.	Residents must demonstrate competence in identifying life-threatening conditions and the most likely diagnosis, synthesizing acquired patient data, and identifying how and when to access current medical information. (Core)
IV.B.1.b).(1).(a).(xi)	establishing and implementing a comprehensive disposition plan that uses appropriate consultation resources, patient education regarding diagnosis, treatment plan, medications, and time and location specific disposition instructions; and, (Core)	4.4.k.	Residents must demonstrate competence in establishing and implementing a comprehensive disposition plan that uses appropriate consultation resources, patient education regarding diagnosis, treatment plan, medications, and time and location specific disposition instructions. (Core)
IV.B.1.b).(1).(a).(xii)	re-evaluating patients undergoing emergency department observation (and monitoring) and using appropriate data and resources, and, determining the differential diagnosis, treatment plan, and disposition. (Core)	4.4.l.	Residents must demonstrate competence in re-evaluating patients undergoing emergency department observation (and monitoring) and using appropriate data and resources, and, determining the differential diagnosis, treatment plan, and disposition. (Core)
IV.B.1.b).(2)	**Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**	**4.5.**	**ACGME Competencies – Patient Care and Procedural Skills (Part B)** **Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**
IV.B.1.b).(2).(a)	Residents must demonstrate competence in:	[None]	
IV.B.1.b).(2).(a).(i)	performing diagnostic and therapeutic procedures and emergency stabilization; (Core)	4.5.a.	Residents must demonstrate competence in performing diagnostic and therapeutic procedures and emergency stabilization. (Core)
IV.B.1.b).(2).(a).(ii)	managing critically ill and injured patients who present to the emergency department, prioritizing critical initial stabilization action, mobilizing hospital support services in the resuscitation of critically-ill or injured patients and reassessing after a stabilizing intervention; (Core)	4.5.b.	Residents must demonstrate competence in managing critically ill and injured patients who present to the emergency department, prioritizing critical initial stabilization action, mobilizing hospital support services in the resuscitation of critically-ill or injured patients and reassessing after a stabilizing intervention. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.B.1.b).(2).(a).(iii)	properly sequencing critical actions for patient care and generating a differential diagnosis for an undifferentiated patient; (Core)	4.5.c.	Residents must demonstrate competence in properly sequencing critical actions for patient care and generating a differential diagnosis for an undifferentiated patient. (Core)
IV.B.1.b).(2).(a).(iv)	mobilizing and managing necessary personnel and other hospital resources to meet critical needs of multiple patients; and, (Core)	4.5.d.	Residents must demonstrate competence in mobilizing and managing necessary personnel and other hospital resources to meet critical needs of multiple patients. (Core)
IV.B.1.b).(2).(a).(v)	performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types on all age groups. (Core)	4.5.e.	Residents must demonstrate competence in performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types on all age groups. (Core)
IV.B.1.b).(2).(b)	Residents must perform indicated procedures on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation, take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)	4.5.f.	Residents must perform indicated procedures on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation, take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)
IV.B.1.b).(2).(c)	Residents must demonstrate competence in performing the following key index procedures:	4.5.g.	Residents must demonstrate competence in performing the following key index procedures:
IV.B.1.b).(2).(c).(i)	adult medical resuscitation; (Core)	4.5.g.1.	adult medical resuscitation; (Core)
IV.B.1.b).(2).(c).(ii)	adult trauma resuscitation; (Core)	4.5.g.2.	adult trauma resuscitation; (Core)
IV.B.1.b).(2).(c).(iii)	anesthesia and pain management; (Core)	4.5.g.3.	anesthesia and pain management; (Core)
IV.B.1.b).(2).(c).(iii).(a)	Residents must provide safe acute pain management, anesthesia, and procedural sedation to patients of all ages regardless of the clinical situation. (Core)	4.5.g.3.a.	Residents must provide safe acute pain management, anesthesia, and procedural sedation to patients of all ages regardless of the clinical situation. (Core)
IV.B.1.b).(2).(c).(iv)	cardiac pacing; (Core)	4.5.g.4.	cardiac pacing; (Core)
IV.B.1.b).(2).(c).(v)	chest tubes; (Core)	4.5.g.5.	chest tubes; (Core)
IV.B.1.b).(2).(c).(vi)	cricothyrotomy; (Core)	4.5.g.6.	cricothyrotomy; (Core)
IV.B.1.b).(2).(c).(vii)	dislocation reduction; (Core)	4.5.g.7.	dislocation reduction; (Core)
IV.B.1.b).(2).(c).(viii)	emergency department bedside ultrasound; (Core)	4.5.g.8.	emergency department bedside ultrasound; (Core)
IV.B.1.b).(2).(c).(viii).(a)	Residents must use ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance. (Core)	4.5.g.8.a.	Residents must use ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance. (Core)
IV.B.1.b).(2).(c).(ix)	intubations; (Core)	4.5.g.9.	intubations; (Core)
IV.B.1.b).(2).(c).(ix).(a)	Residents must perform airway management on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation); take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)	4.5.g.9.a.	Residents must perform airway management on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation); take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)
IV.B.1.b).(2).(c).(x)	lumbar puncture; (Core)	4.5.g.10.	lumbar puncture; (Core)
IV.B.1.b).(2).(c).(xi)	pediatric medical resuscitation; (Core)	4.5.g.11.	pediatric medical resuscitation; (Core)
IV.B.1.b).(2).(c).(xii)	pediatric trauma resuscitation; (Core)	4.5.g.12.	pediatric trauma resuscitation; (Core)
IV.B.1.b).(2).(c).(xiii)	pericardiocentesis; (Core)	4.5.g.13.	pericardiocentesis; (Core)
IV.B.1.b).(2).(c).(xiv)	procedural sedation; (Core)	4.5.g.14.	procedural sedation; (Core)
IV.B.1.b).(2).(c).(xv)	vaginal delivery; (Core)	4.5.g.15.	vaginal delivery; (Core)
IV.B.1.b).(2).(c).(xvi)	vascular access; and, (Core)	4.5.g.16.	vascular access; and, (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.B.1.b).(2).(c).(xvi).(a)	Residents must successfully obtain vascular access in patients of all ages regardless of the clinical situation. (Core)	4.5.g.16.a.	Residents must successfully obtain vascular access in patients of all ages regardless of the clinical situation. (Core)
IV.B.1.b).(2).(c).(xvii)	wound management. (Core)	4.5.g.17.	wound management. (Core)
IV.B.1.b).(2).(c).(xvii).(a)	Residents must assess and appropriately manage wounds in patients of all ages regardless of the clinical situation. (Core)	4.5.g.17.a.	Residents must assess and appropriately manage wounds in patients of all ages regardless of the clinical situation. (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 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)**
IV.B.1.c).(1)	Residents must demonstrate appropriate medical knowledge in the care of emergency medicine patients; and, (Core)	4.6.a.	Residents must demonstrate appropriate medical knowledge in the care of emergency medicine patients. (Core)
IV.B.1.c).(2)	Residents must demonstrate knowledge of the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values. (Core)	4.6.b.	Residents must demonstrate knowledge of the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values. (Core)
IV.B.1.d)	**Practice-based Learning and Improvement** **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-Based Learning and Improvement** **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)**
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 competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise. (Core)**
IV.B.1.d).(1).(b)	**setting learning and improvement goals; (Core)**	**4.7.b.**	**Residents must demonstrate competence in setting learning and improvement goals. (Core)**
IV.B.1.d).(1).(c)	**identifying and performing appropriate learning activities; (Core)**	**4.7.c.**	**Residents must demonstrate competence in identifying and performing 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 competence in 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)**
IV.B.1.d).(1).(e)	**incorporating feedback and formative evaluation into daily practice; and, (Core)**	**4.7.e.**	**Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice. (Core)**
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 competence in locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)**
IV.B.1.d).(1).(g)	applying knowledge of study design and statistical methods to critically appraise the medical literature; (Core)	4.7.g.	Residents must demonstrate competence in applying knowledge of study design and statistical methods to critically appraise the medical literature. (Core)
IV.B.1.d).(1).(h)	using information technology to improve patient care; (Core)	4.7.h.	Residents must demonstrate competence in using information technology to improve patient care. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.B.1.d).(1).(i)	evaluating teaching effectiveness; and, (Core)	4.7.i.	Residents must demonstrate competence in evaluating teaching effectiveness. (Core)
IV.B.1.d).(1).(j)	teaching different audiences using appropriate strategies based on targeted learning objectives. (Core)	4.7.j.	Residents must demonstrate competence in teaching different audiences using appropriate strategies based on targeted learning objectives. (Core)
IV.B.1.e)	**Interpersonal and Communication Skills** **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 – Interpersonal and Communication Skills** **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)**
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 competence in 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)**
IV.B.1.e).(1).(b)	**communicating effectively with physicians, other health professionals, and health-related agencies; (Core)**	**4.8.b.**	**Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-related agencies. (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 competence in working effectively as a member or leader of a health care team or other professional group. (Core)**
IV.B.1.e).(1).(d)	**educating patients, patients' families, students, other residents, and other health professionals; (Core)**	**4.8.d.**	**Residents must demonstrate competence in educating patients, patients' families, students, other residents, and other health professionals. (Core)**
IV.B.1.e).(1).(e)	**acting in a consultative role to other physicians and health professionals; (Core)**	**4.8.e.**	**Residents must demonstrate competence in acting in a consultative role to other physicians and health professionals. (Core)**
IV.B.1.e).(1).(f)	**maintaining comprehensive, timely, and legible health care records, if applicable. (Core)**	**4.8.f.**	**Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable. (Core)**
IV.B.1.e).(1).(g)	communicating sensitive issues or unexpected outcomes, including: (Core)	4.8.h.	Residents must demonstrate competence in communicating sensitive issues or unexpected outcomes, including: (Core)
IV.B.1.e).(1).(g).(i)	diagnostic findings; (Core)	4.8.h.1.	diagnostic findings; (Core)
IV.B.1.e).(1).(g).(ii)	end-of-life issues and death; and, (Core)	4.8.h.2.	end-of-life issues and death; and, (Core)
IV.B.1.e).(1).(g).(iii)	medical errors. (Core)	4.8.h.3.	medical errors. (Core)
IV.B.1.e).(1).(h)	leading patient care teams, ensuring effective communication and mutual respect among team members. (Core)	4.8.i.	Residents must demonstrate competence in leading patient care teams, ensuring effective communication and mutual respect among team members. (Core)
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 with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**
IV.B.1.f)	**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 other resources to provide optimal health care. (Core)**	**4.9.**	**ACGME Competencies - 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 other resources to provide optimal health care. (Core)**
IV.B.1.f).(1)	**Residents must demonstrate competence in:**	**[None]**	

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.B.1.f).(1).(a)	**working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)**	**4.9.a.**	**Residents must demonstrate competence in working effectively in various health care delivery settings and systems relevant to their clinical 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 competence in coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty. (Core)**
IV.B.1.f).(1).(c)	**advocating for quality patient care and optimal patient care systems; (Core)**	**4.9.c.**	**Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems. (Core)**
IV.B.1.f).(1).(d)	**participating in identifying system errors and implementing potential systems solutions; (Core)**	**4.9.d.**	**Residents must demonstrate competence in participating in identifying system errors and implementing potential systems solutions. (Core)**
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 competence in incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate. (Core)**
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 competence in understanding health care finances and its impact on individual patients' health decisions. (Core)**
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 competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)**
IV.B.1.f).(1).(h)	participation in performance improvement to optimize self-learning, emergency department function, and patient safety; and, (Core)	4.9.i.	Residents must demonstrate competence in participation in performance improvement to optimize self-learning, emergency department function, and patient safety. (Core)
IV.B.1.f).(1).(i)	using technology to accomplish and document safe health care delivery. (Core)	4.9.j.	Residents must demonstrate competence in using technology to accomplish and document safe health care delivery. (Core)
IV.B.1.f).(2)	**Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)**	**4.9.h.**	**Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)**
IV.C.	**Curriculum Organization and Resident Experiences**	**4.10. - 4.12.**	**Curriculum Organization and Resident Experiences** **4.10. Curriculum Structure** **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)** **4.11. Didactic and Clinical Experiences** **Residents must be provided with protected time to participate in core didactic activities. (Core)** **4.12. Pain Management** **The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 Structure** **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)**
IV.C.1.a)	Clinical experiences should be structured to facilitate learning in a manner that allows the residents to function as part of an effective interprofessional team that works together toward the shared goals of patient safety and quality improvement. (Detail)	4.10.a.	Clinical experiences should be structured to facilitate learning in a manner that allows the residents to function as part of an effective interprofessional team that works together toward the shared goals of patient safety and quality improvement. (Detail)
IV.C.1.a).(1)	The emergency medicine program director is responsible for determining the duration of the clinical experiences for the emergency medicine residents on all rotations. (Core)	4.10.b.	The emergency medicine program director is responsible for determining the duration of the clinical experiences for the emergency medicine residents on all rotations. (Core)
IV.C.2.	**The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**	**4.12.**	**Pain Management** **The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**
IV.C.3.	Didactics	4.11.a.	Didactics Didactic experiences must include administrative seminars, journal review, presentations based on the defined curriculum, morbidity and mortality conferences, and research seminars. (Core)
IV.C.3.a)	Didactic experiences must include administrative seminars, journal review, presentations based on the defined curriculum, morbidity and mortality conferences, and research seminars. (Core)	4.11.a.	Didactics Didactic experiences must include administrative seminars, journal review, presentations based on the defined curriculum, morbidity and mortality conferences, and research seminars. (Core)
IV.C.3.a).(1)	These didactic experiences should include joint conferences co-sponsored with other disciplines. (Core)	4.11.a.1.	These didactic experiences should include joint conferences co-sponsored with other disciplines. (Core)
IV.C.3.a).(2)	Educational methods should include problem-based learning, evidence-based learning, and computer-based instruction. (Core)	4.11.a.2.	Educational methods should include problem-based learning, evidence-based learning, and computer-based instruction. (Core)
IV.C.3.b)	The majority of didactic experiences must occur at the primary clinical site. (Core)	4.11.a.3.	The majority of didactic experiences must occur at the primary clinical site. (Core)
IV.C.3.c)	There must be an average of at least five hours per week of planned didactic experiences developed by the program's faculty members. (Core)	4.11.a.4.	There must be an average of at least five hours per week of planned didactic experiences developed by the program's faculty members. (Core)
IV.C.3.c).(1)	Individualized interactive instruction must not exceed 20 percent of the planned didactic experiences. (Core)	4.11.a.5.	Individualized interactive instruction must not exceed 20 percent of the planned didactic experiences. (Core)
IV.C.3.c).(2)	All planned didactic experiences must be supervised by core physician faculty members. (Core)	4.11.a.6.	All planned didactic experiences must be supervised by core physician faculty members. (Core)
IV.C.3.c).(3)	Each core physician faculty member must attend, on average per year, at least 20 percent of planned didactic experiences. (Core)	4.11.a.7.	Each core physician faculty member must attend, on average per year, at least 20 percent of planned didactic experiences. (Core)
IV.C.3.c).(4)	Emergency medicine faculty members must present at least 50 percent of resident conferences. (Core)	4.11.a.8.	Emergency medicine faculty members must present at least 50 percent of resident conferences. (Core)
IV.C.3.c).(5)	Residents must actively participate, on average, in at least 70 percent of the planned didactic experiences offered. (Core)	4.11.a.9.	Residents must actively participate, on average, in at least 70 percent of the planned didactic experiences offered. (Core)
I.A.1.a).(1)	All planned didactic experiences must have an evaluative component to measure resident participation and educational effectiveness. (Core)	4.11.a.10.	All planned didactic experiences must have an evaluative component to measure resident participation and educational effectiveness. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.C.4.	Curriculum The curriculum must include:	4.11.b.	Curriculum The curriculum must include four months of dedicated critical care experiences, including critical care of infants and children. (Core)
IV.C.4.a)	four months of dedicated critical care experiences, including critical care of infants and children; (Core)	4.11.b.	Curriculum The curriculum must include four months of dedicated critical care experiences, including critical care of infants and children. (Core)
IV.C.4.a).(1)	At least two months of these experiences must be at the PGY-2 level or above. (Core)	4.11.b.1.	At least two months of these experiences must be at the PGY-2 level or above. (Core)
IV.C.4.b)	five FTE months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department or other pediatric settings; (Core)	4.11.c.	The curriculum must include five FTE months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department or other pediatric settings. (Core)
IV.C.4.b).(1)	At least 50 percent of the five months should be in an emergency setting. (Core)	4.11.c.1.	At least 50 percent of the five months should be in an emergency setting. (Core)
IV.C.4.b).(2)	This experience must include the critical care of infants and children. (Core)	4.11.c.2.	This experience must include the critical care of infants and children. (Core)
IV.C.4.c)	at least 10 low-risk normal spontaneous vaginal deliveries; and, (Core)	4.11.d.	The curriculum must include at least 10 low-risk normal spontaneous vaginal deliveries. (Core)
IV.C.4.d)	at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in the emergency department under the supervision of emergency medicine faculty members. (Core)	4.11.e.	The curriculum must include at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in the emergency department under the supervision of emergency medicine faculty members. (Core)
IV.C.4.d).(1)	Residents should treat a significant number of critically ill or critically injured patients at participating sites. (Core)	4.11.e.1.	Residents should treat a significant number of critically ill or critically injured patients at participating sites. (Core)
IV.C.4.d).(1).(a)	These patients should be those admitted to intensive care units, operative care, or the morgue following treatment in the emergency department. (Core)	4.11.e.1.a.	These patients should be those admitted to intensive care units, operative care, or the morgue following treatment in the emergency department. (Core)
IV.C.5.	Resident Experiences	4.11.f.	Resident Experiences Each resident must maintain, in an accurate and timely manner, a record of all major resuscitations and procedures performed throughout the entire educational program. (Core)
IV.C.5.a)	Each resident must maintain, in an accurate and timely manner, a record of all major resuscitations and procedures performed throughout the entire educational program. (Core)	4.11.f.	Resident Experiences Each resident must maintain, in an accurate and timely manner, a record of all major resuscitations and procedures performed throughout the entire educational program. (Core)
IV.C.5.a).(1)	The record must document each procedure type, adult or pediatric patient, and circumstances of each procedure (live or simulation). (Core)	4.11.f.1.	The record must document each procedure type, adult or pediatric patient, and circumstances of each procedure (live or simulation). (Core)
IV.C.5.a).(2)	Only one resident must be credited with the direction of each resuscitation and the performance of each procedure. (Core)	4.11.f.2.	Only one resident must be credited with the direction of each resuscitation and the performance of each procedure. (Core)
IV.C.5.a).(3)	Resident experiences with major resuscitations and procedures must at least meet the procedural minimums as defined by the Review Committee where indicated. (Core)	4.11.f.3.	Resident experiences with major resuscitations and procedures must at least meet the procedural minimums as defined by the Review Committee where indicated. (Core)
IV.C.5.b)	Residents must have experience in emergency medical services (EMS), emergency preparedness, and disaster management. (Core)	4.11.g.	Residents must have experience in emergency medical services (EMS), emergency preparedness, and disaster management. (Core)
IV.C.5.b).(1)	EMS experiences must include ground unit runs and should include direct medical oversight. (Core)	4.11.g.1.	EMS experiences must include ground unit runs and should include direct medical oversight. (Core)
IV.C.5.b).(2)	This should include participation in multi-casualty incident drills. (Core)	4.11.g.2.	This should include participation in multi-casualty incident drills. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.C.5.b).(3)	If programs allow residents to ride in air ambulance units, the residents must be notified in writing of the associated risks prior to their first flight. (Core)	4.11.g.3.	If programs allow residents to ride in air ambulance units, the residents must be notified in writing of the associated risks prior to their first flight. (Core)
IV.C.5.b).(3).(a)	Residents must be given the opportunity to opt out of riding in air ambulance units at any point in residency. (Core)	4.11.g.3.a.	Residents must be given the opportunity to opt out of riding in air ambulance units at any point in residency. (Core)
IV.D.	**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.*** ***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]**	**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.*** ***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.***
IV.D.1.	**Program Responsibilities**	**4.13.**	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities consistent 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 evidence of scholarly activities consistent 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 Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in 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' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.D.2.	Faculty Scholarly Activity	4.14.	Faculty Scholarly Activity Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core) • Research in basic science, education, translational science, patient care, or population health • Peer-reviewed grants • Quality improvement and/or patient safety initiatives • 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 editorial boards • Innovations in education
IV.D.2.a)	Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core) • Research in basic science, education, translational science, patient care, or population health • Peer-reviewed grants • Quality improvement and/or patient safety initiatives • 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 editorial boards • Innovations in education	4.14.	Faculty Scholarly Activity Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core) • Research in basic science, education, translational science, patient care, or population health • Peer-reviewed grants • Quality improvement and/or patient safety initiatives • 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 editorial boards • Innovations in education
IV.D.2.b)	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:	4.14.a.	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods: • faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome) • peer-reviewed publication. (Outcome)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.D.2.b).(1)	**faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)**	**4.14.a.**	**The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:** **• faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)** **• peer-reviewed publication. (Outcome)**
IV.D.2.b).(2)	**peer-reviewed publication. (Outcome)**	**4.14.a.**	**The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:** **• faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)** **• peer-reviewed publication. (Outcome)**
IV.D.3.	**Resident Scholarly Activity**	**4.15.**	**Resident Scholarly Activity** **Residents must participate in scholarship. (Core)**
IV.D.3.a)	**Residents must participate in scholarship. (Core)**	**4.15.**	**Resident Scholarly Activity** **Residents must participate in scholarship. (Core)**
IV.D.3.b)	The curriculum must advance the residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)	4.15.a.	The curriculum must advance the residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)
IV.D.3.c)	At the time of graduation, each resident should demonstrate:	4.15.b.	At the time of graduation, each resident should demonstrate: • active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an emergency department quality improvement project; or, (Outcome) • presentation of grand rounds, posters, workshops, quality improvement presentations, podium presentations, webinars; or, (Core) • grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; or, (Outcome) • peer-reviewed publications. (Outcome)

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IV.D.3.c).(1)	active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an emergency department quality improvement project; or, (Outcome)	4.15.b.	At the time of graduation, each resident should demonstrate: • active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an emergency department quality improvement project; or, (Outcome) • presentation of grand rounds, posters, workshops, quality improvement presentations, podium presentations, webinars; or, (Core) • grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; or, (Outcome) • peer-reviewed publications. (Outcome)
IV.D.3.c).(2)	presentation of grand rounds, posters, workshops, quality improvement presentations, podium presentations, webinars; or, (Core)	4.15.b.	At the time of graduation, each resident should demonstrate: • active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an emergency department quality improvement project; or, (Outcome) • presentation of grand rounds, posters, workshops, quality improvement presentations, podium presentations, webinars; or, (Core) • grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; or, (Outcome) • peer-reviewed publications. (Outcome)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
IV.D.3.c).(3)	grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; or, (Outcome)	4.15.b.	At the time of graduation, each resident should demonstrate: • active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an emergency department quality improvement project; or, (Outcome) • presentation of grand rounds, posters, workshops, quality improvement presentations, podium presentations, webinars; or, (Core) • grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; or, (Outcome) • peer-reviewed publications. (Outcome)
V.	**Evaluation**	**Section 5**	**Section 5: Evaluation**
V.A.	**Resident Evaluation**	**5.1.**	**Resident Evaluation: Feedback and Evaluation** **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**
V.A.1.	**Feedback and Evaluation**	**5.1.**	**Resident Evaluation: Feedback and Evaluation** **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**
V.A.1.a)	**Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**	**5.1.**	**Resident Evaluation: Feedback and Evaluation** **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**
V.A.1.b)	**Evaluation must be documented at the completion of the assignment. (Core)**	**5.1.a.**	**Evaluation must be documented at the completion of the assignment. (Core)**
V.A.1.b).(1)	**For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**	**5.1.a.1.**	**For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**
V.A.1.b).(2)	**Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)**	**5.1.a.2.**	**Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)**
V.A.1.c)	**The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)**	**5.1.b.**	**The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones. (Core)**
V.A.1.c).(1)	**use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)**	**5.1.b.1.**	**The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)**
V.A.1.c).(2)	**provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)**	**5.1.b.2.**	**The program must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)**
V.A.1.d)	**The program director or their designee, with input from the Clinical Competency Committee, must:**	**[None]**	

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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)**	**5.1.c.**	**The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones. (Core)**
V.A.1.d).(1).(a)	The program director must verify each resident's records of major resuscitations and procedures as part of the semiannual evaluation. (Core)	5.1.c.1.	The program director must verify each resident's records of major resuscitations and procedures as part of the semiannual evaluation. (Core)
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 designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and identify 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 designee, with input from the Clinical Competency Committee, must develop plans for residents failing to progress, following institutional policies and procedures. (Core)**
V.A.1.d).(3).(a)	A plan to remedy deficiencies must be in writing and on file. (Core)	5.1.e.1.	A plan to remedy deficiencies must be in writing and on file. (Core)
V.A.1.d).(3).(a).(i)	Progress and improvement must be monitored at a minimum of every three months if a resident has been identified as needing a remediation plan. (Core)	5.1.e.1.a.	Progress and improvement must be monitored at a minimum of every three months if a resident has been identified as needing a remediation plan. (Core)
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 summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)**
V.A.1.e).(1)	At least annually, each resident's competency in procedures and resuscitations must be formally evaluated by the program director. (Core)	5.1.f.1.	At least annually, each resident's competency in procedures and resuscitations must be formally evaluated by the program director. (Core)
V.A.1.f)	**The evaluations of a resident's performance must be accessible for review by the resident. (Core)**	**5.1.g.**	**The evaluations of a resident's performance must be accessible for review by the resident. (Core)**
V.A.2.	**Final Evaluation**	**5.2.**	**Resident Evaluation: Final Evaluation** **The program director must provide a final evaluation for each resident upon completion of the program. (Core)**
V.A.2.a)	**The program director must provide a final evaluation for each resident upon completion of the program. (Core)**	**5.2.**	**Resident Evaluation: Final Evaluation** **The program director must provide a final evaluation for each resident upon completion of the program. (Core)**
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 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)**
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 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)**
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 resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (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 with the resident upon completion of 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 must be appointed by the program director. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 Competency Committee must include three members of the program faculty, at least one of whom is a core faculty 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 members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)
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 must review all resident evaluations 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 must determine each resident's progress on achievement of the specialty-specific Milestones. (Core)
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 must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)
V.B.	Faculty Evaluation	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (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 evaluate each faculty member's performance as it relates to the educational program at least annually. (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 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)
V.B.1.b)	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)	5.4.b.	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)
V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feedback on their evaluations at least 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 evaluations should be incorporated into program-wide faculty development plans. (Core)
V.C.	Program Evaluation and Improvement	5.5.	Program Evaluation and Improvement 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)
V.C.1.	The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1.a)	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 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)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
V.C.1.b).(1)	review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)
V.C.1.b).(3)	review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)
V.C.1.c)	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 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)
V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)	5.5.f.	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)
V.C.1.e)	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, 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)
V.C.2.	The program must complete a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must complete a Self-Study and submit it to the DIO. (Core)
V.C.3.	*One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.* *The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.*	[None]	Board Certification *One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.* *The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.*
V.C.3.a)	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 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)
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 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)
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 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)

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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 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)
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 5.6.a.-c., 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)
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 certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)
VI.	The Learning and Working Environment *Residency education must occur in the context of a learning and working environment that emphasizes the following principles:* *• Excellence in the safety and quality of care rendered to patients by residents today* *• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice* *• Excellence in professionalism* *• Appreciation for the privilege of caring for patients* *• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*	Section 6	Section 6: The Learning and Working Environment The Learning and Working Environment *Residency education must occur in the context of a learning and working environment that emphasizes the following principles:* *• Excellence in the safety and quality of care rendered to patients by residents today* *• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice* *• Excellence in professionalism* *• Appreciation for the privilege of caring for patients* *• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*
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]	
VI.A.1.a).(1)	Culture of Safety *A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.*	[None]	Culture of Safety *A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.*
VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)	6.1.	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.A.1.a).(2)	**Patient Safety Events** ***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***	[None]	**Patient Safety Events** ***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***
VI.A.1.a).(2).(a)	**Residents, fellows, faculty members, and other clinical staff members must:**	[None]	
VI.A.1.a).(2).(a).(i)	**know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)**	6.2.	**Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)**
VI.A.1.a).(2).(a).(ii)	**be provided with summary information of their institution's patient safety reports. (Core)**	6.2.a.	**Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports.** (Core)
VI.A.1.a).(2).(b)	**Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)**	6.3.	**Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)**
VI.A.1.a).(3)	**Quality Metrics** ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***	[None]	**Quality Metrics** ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***
VI.A.1.a).(3).(a)	**Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)**	6.4.	**Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)**
VI.A.2.	**Supervision and Accountability**	[None]	**Supervision and Accountability** ***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.***

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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.***	[None]	**Supervision and Accountability** ***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.***
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 inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)**
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 inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)**
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 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)**
VI.A.2.b)	**Levels of Supervision** **To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:**	[None]	**Levels of Supervision** ***To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.***
VI.A.2.b).(1)	**Direct Supervision:**	6.7.	**Direct Supervision** ***The supervising physician is physically present with the resident during the key portions of the patient interaction.*** ***The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.***
VI.A.2.b).(1).(a)	**the supervising physician is physically present with the resident during the key portions of the patient interaction; or,**	6.7.	**Direct Supervision** ***The supervising physician is physically present with the resident during the key portions of the patient interaction.*** ***The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.***

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 supervised directly, only as described in the above definition. (Core)
VI.A.2.b).(1).(b)	the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.	6.7.	Direct Supervision *The supervising physician is physically present with the resident during the key portions of the patient interaction.* *The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.*
VI.A.2.b).(2)	Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.	[None]	Indirect Supervision *The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.*
VI.A.2.b).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.	[None]	Oversight *The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.*
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physical presence of a supervising 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 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)
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 each resident's abilities based on specific criteria, guided by the Milestones. (Core)
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 supervising physicians must delegate portions of care to residents based on the needs of the patient and the 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)	6.9.c.	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)
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 circumstances and events in which residents must communicate with the supervising faculty member(s). (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 their scope of authority, and the circumstances under which the resident is permitted to act with 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 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)
VI.B.	Professionalism	6.12.	Professionalism 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)

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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 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)
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 program must be accomplished without excessive reliance on residents to fulfill non-physician obligations. (Core)
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the program must ensure manageable patient care responsibilities. (Core)
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 must 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)
VI.B.3.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)	6.12.d.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and 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 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)
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 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)
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 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)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.C.	**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.*** ***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]	**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.*** ***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.***
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program, in partnership with the Sponsoring 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 intensity, and work compression that impacts resident well-being; (Core)
VI.C.1.b)	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)	6.13.b.	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)
VI.C.1.c)	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)	6.13.c.	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)
VI.C.1.c).(1)	Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)	6.13.c.1.	Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty members in:
VI.C.1.d).(1)	identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)	6.13.d.1.	identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)
VI.C.1.d).(2)	recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)	6.13.d.2.	recognition of these symptoms in themselves and how to seek 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)
VI.C.1.e)	providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)	6.13.e.	providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)
VI.C.2.	There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)	6.14.	There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.C.2.a)	**The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)**	**6.14.a.**	**The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)**
VI.C.2.b)	**These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)**	**6.14.b.**	**These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)**
VI.D.	**Fatigue Mitigation**	**6.15.**	**Fatigue Mitigation** **Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)**
VI.D.1.	**Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)**	**6.15.**	**Fatigue Mitigation** **Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)**
VI.D.2.	**The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)**	**6.16.**	**The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)**
VI.E.	**Clinical Responsibilities, Teamwork, and Transitions of Care**	**[None]**	
VI.E.1.	**Clinical Responsibilities** **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.**	**Clinical Responsibilities** **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)**
VI.E.1.a)	When emergency medicine residents are on emergency medicine rotations, the following standards apply: (Core)	6.17.a.	When emergency medicine residents are on emergency medicine rotations, the following standards apply: (Core)
VI.E.1.a).(1)	While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. (Core)	6.17.a.1.	While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. (Core)
VI.E.1.a).(1).(a)	There must be at least one equivalent period of continuous time off between scheduled work period. (Core)	6.17.a.2.	There must be at least one equivalent period of continuous time off between scheduled work period. (Core)
VI.E.1.a).(2)	A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week. (Core)	6.17.a.3.	A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week. (Core)
VI.E.1.a).(3)	Emergency medicine residents must have a minimum of one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period. (Core)	6.17.a.4.	Emergency medicine residents must have a minimum of one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period. (Core)
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 an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)**
VI.E.2.a)	Interprofessional teams should be used to ensure effective and efficient communication for appropriate patient care for emergency medicine department admissions, transfers, and discharges. (Detail)	6.18.a.	Interprofessional teams should be used to ensure effective and efficient communication for appropriate patient care for emergency medicine department admissions, transfers, and discharges. (Detail)
VI.E.3.	**Transitions of Care**	**6.19.**	**Transitions of Care** **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)
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 Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)
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 are competent in communicating with team members in the hand-off process. (Outcome)
VI.F.	Clinical Experience and Education *Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.*	[None]	Clinical Experience and Education *Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.*
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 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)
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	Mandatory Time Free of Clinical Work and Education Residents should have eight hours off between scheduled clinical work 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 and Education Residents should have eight hours off between scheduled clinical work 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 free of clinical work and education 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 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)
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	Maximum Clinical Work and Education Period Length Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)
VI.F.3.a)	Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)	6.22.	Maximum Clinical Work and Education Period Length Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)
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 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)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.F.4.	**Clinical and Educational Work Hour Exceptions**	**6.23.**	**Clinical and Educational Work Hour Exceptions** **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)**
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 Exceptions** **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)**
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 education must be counted toward the 80-hour weekly limit. (Detail)**
VI.F.4.c)	**A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.** The Review Committee for Emergency Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.	**6.24.**	**A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.** The Review Committee for Emergency Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.F.5.	**Moonlighting**	**6.25.**	**Moonlighting** **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)**
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 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)**
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 and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour 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 moonlight. (Core)**
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 context of the 80-hour and one-day-off-in-seven requirements. (Core)**
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 Frequency** **Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.F.8.	At-Home Call	6.28.	At-Home Call 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)
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 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)
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 or taxing as to preclude rest or reasonable personal time for each resident. (Core)