**TRAINING AWAY FROM ACCREDITED PROGRAM REQUEST**

|  |
| --- |
| There is no need for Program Directors to inform the ABA about residents’ and fellows’ training away of four weeks or less for:   * Established international rotations * ASA advocacy rotations or Texas advocacy rotations * Instances where all Clinical Competence Committee (CCC) reports are satisfactory * Training away that does not occur during the CA-1 year or first month of a fellowship * Previously approved training away rotations and newly requested rotations combined that do not exceed one-month cumulative   For requests that do not meet the criteria above, please note that we must receive the request from the Program Director **at least four months** before the resident or fellow begins the training away. You may email your completed request form to [casemanagement@theaba.org](mailto:casemanagement@theaba.org). See our Policy Book at [www.theaba.org](http://www.theaba.org) for more information.  **PLEASE NOTE FOR FELLOWS:**  We will accept no more than two months of training in institutions not recognized by the ACGME as part of the accredited subspecialty program. Therefore, fellows must complete a minimum of 10 months of training in their ACGME-accredited subspecialty program. |

Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Program Number: \_\_\_\_\_\_ \_\_

Resident/Fellow Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ ABA ID Number(s): \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Dates of Rotation: From: Click or tap to enter a date. To: Click or tap to enter a date.

Total # of Rotation Days: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervising Physician’s Name and Position (attach CV): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will the resident/fellow remain enrolled in his/her accredited program while training away from the accredited program:

Yes No

Is the resident/fellow in good standing at the time of the request:

Yes No

Assurance that the resident’s/fellow’s accredited program will report the training on the semi-annual Clinical Competency Committee report while training away from the program:

Yes

**Please answer the following questions about the facility/institution at which the proposed training would take place:**

1. Name of facility/institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Location of facility/institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Is there an RRC-approved affiliation or integration agreement with the parent institution? Yes No
4. Is the institution at which the training will occur accredited by the ACGME?

Yes No

1. If no, is the facility a participating institution that is affiliated or integrated with another ACGME-accredited anesthesiology program?

Yes No

**Please answer each of the following questions about all rotations the physician has previously completed away from his/her accredited program to date. *Please indicate all times in weeks or months.***

1. The total time, to date, the physician has spent training in facilities that are affiliated or integrated with his/her parent institution under a written agreement approved by the RRC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. The total time, to date, the physician has spent training away from his/her accredited program at other ACGME-accredited anesthesiology programs or their integrated/affiliated institutions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. The total time, to date, the physician has spent training away from his/her accredited program at other institutions/facilities that are **not** ACGME-accredited: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide a chronological description of the proposed rotations:**

|  |
| --- |
|  |

Additional Comments (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_