**TRAINING AWAY FROM ACCREDITED PROGRAM REQUEST**

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| 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. 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:**

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

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