TEXAS TECH HEALTH SCIENCES CENTER
Paul L. Foster School of Medicine
GRADUATE MEDICAL EDUCATION
Standard Policy and/or Procedure

TITLE:	Program Expansion
APPROVED:	2/12/2009
REVISED:	
EFFECTIVE DATE:	2/12/2009
PURPOSE:	To establish a procedure by which a proposal for program expansion will be reviewed by the GMEC for final approval by the Dean.

PROCEDURE STATEMENT: A clinical department with an existing graduate medical education training program that it seeks to expand shall follow the procedure outlined below:

1. Discussion regarding the expansion of an existing program shall begin in the clinical department and there should be full faculty support for the proposed expansion.
2. Consultation with the Associate Dean for Graduate Medical Education/DIO is also available and advisable.
3. The GME Program Expansion Request Form must be completed and submitted to the Office of Graduate Medical Education for review by the Graduate Medical Education Committee (GMEC).
4. The Program Director shall present the Request to the GMEC for review and consideration.
5. The GMEC will make a recommendation and forward same to the Dean for approval based on the educational rationale for an expansion request.
6. Upon approval by the Dean, the Program Director may submit a request to increase the resident complement to the ACGME via WebADS.

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
at El Paso

Paul L. Foster School of Medicine
GRADUATE MEDICAL EDUCATION
PROGRAM EXPANSION REQUEST FORM

PROGRAM (Specialty): _____
PROGRAM DIRECTOR: _____

1. The requested program / change is: ____ permanent ____ temporary

2. When do you wish to initiate the change, i.e. add additional residents (mm/yy)? _____

3. If temporary, when would the expansion end (mm/yy)? _____

4. Briefly describe the proposed expansion and the objective/rational for increasing the program size.

5. Provide the number (s) of additional residents added each year of the program expansion.

PGY/Yr.	1st (mm/yy)	2nd (mm/yy)	3rd (mm/yy)	4th (mm/yy)	5th (mm/yy)
PGY 1					
PGY 2					
PGY 3					
PGY 4					
PGY 5					
PGY 6					
TOTAL					

6. What is the program's current ACGME / Institutional approved number of residents? Total _____

PGY 1 ___ PGY 2 ___ PGY 3 ___ PGY 4 ___ PGY 5 ___ PGY 6 ___

7. What is your current complement of filled positions? Total _____

PGY 1 ___ PGY 2 ___ PGY 3 ___ PGY 4 ___ PGY 5 ___ PGY 6 ___

8. What protocol is required by your RRC to increase the number of residents?

9. What is your status with regard to the RRC protocol requirement?

10. To accommodate the requested increase, do you have sufficient
    Faculty: ___ Yes ___ No
    Clinical Material / Patients: ___ Yes ___ No

11. What impact will the expansion have on other departments/hospitals?

Other Departments:

Hospitals:

12. Have you obtained a commitment to support the expansion from the other departments/hospitals impacted? _____ Yes _____ No

13. Identify the amount of funding (salary, fringe, malpractice) required per year to support the expansion.

PGY/Yr.	1st (mm/yy)	2nd (mm/yy)	3rd (mm/yy)	4th (mm/yy)	5th (mm/yy)
PGY 1					
PGY 2					
PGY 3					
PGY 4					
PGY 5					
PGY 6					
TOTAL					

14. Identify the source of funding (Department, External Source, etc.) required for the expansion.

15. Delineate the protocol for transferring funds to TTUHSC GME account. (If in-house, include acct. #; if an external source will provide funding, attach the letter of commitment.

SIGNATURES:
Program Director: _____ Date: _____

Department Chair: _____ Date: _____

Source of funding fiscal agent: _____ Date: _____

Review

CONCUR					
Yes	**No**	**Title**	**Name**	**Signature**	**Date**
		Designated Institutional Official GME			
		Associate Dean, Finance and Administration			

Approval

Dean, PLF-SOM: _____ Date: _____