

## Checklist for Those Entering Fellowship Programs

Although this documentation is not an ACGME requirement for those trainees entering a fellowship program at the completion of a current residency or fellowship program, it is recommended that fellowship programs due "due diligence" and obtain this information near the end of the trainee's core residency program prior to the writing of a URMC contract.

### From ACGME Common Requirements:

#### *III C.1. Resident Transfers*

"Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident." Clarification from the ACGME on this issue: This includes (1) evaluations, (2) rotations completed, (3) procedural/operative experience, and (4) an interim evaluation (see attached), and (5) a summative competency-based performance evaluation from the sending program director no later than July 31<sup>st</sup>.

Note: The ACGME uses the generic term "resident" whether addressing residents or fellows.

### Guidelines to Follow

1. Send completed checklist to GME Office along with a duplicate application package. The applicable 600/610 form can be sent at a later date. "Due diligence" must be done before a contract is issued by the GME Office.
2. **Each of the items listed below must be completed and included with this form and sent to the GME Office.**

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Future Trainee Name (print): \_\_\_\_\_

Current Training Program: (e.g., internal medicine, surgery) \_\_\_\_\_

Program Name/Location (e.g. Albany Medical Center, NY) \_\_\_\_\_

US citizen? \_\_\_\_ Yes; \_\_\_\_ No      If no, indicate visa status: \_\_\_\_\_

Please attach the following:

- 1) Rotations completed to date
- 2) Procedure/operative experience record to date
- 3) Interim transfer competency-based performance evaluation (attached)
- 4) Educational and work history chronological timeline (see GME web site, new hire checklist)
- 5) ECFMG certificate if an international medical graduate



**Office of Graduate Medical Education  
INTERIM TRANSFER EVALUATION  
(to be completed by Current Program Director)**

Trainee Name: \_\_\_\_\_ Institution Name: \_\_\_\_\_

Program: \_\_\_\_\_ Current PGY Level: \_\_\_\_\_

In current program --  
Training Start Date: \_\_\_\_\_ Anticipated Training End Date: \_\_\_\_\_

**THE FOLLOWING ARE REQUIRED AND MUST BE ATTACHED TO THIS FORM: (1) Rotations completed to date; (2) Procedure/operative experience record to date (if applicable).**

**At this point, the trainee is displaying an acceptable level of competence for each of the following ACGME's core competencies based on his/her level of training.:**

<b>Patient Care:</b>	<b>Yes</b>	<b>No</b>
<b>Medical Knowledge:</b>	<b>Yes</b>	<b>No</b>
<b>Interpersonal and Communication Skills:</b>	<b>Yes</b>	<b>No</b>
<b>Professionalism:</b>	<b>Yes</b>	<b>No</b>
<b>Practice-Based Learning and Improvement:</b>	<b>Yes</b>	<b>No</b>
<b>Systems-Based Practice:</b>	<b>Yes</b>	<b>No</b>

**To your knowledge has this physician:**

1. Ever been on probation during the training program?	<b>NO</b>	<b>YES</b>
2. Any pending professional misconduct proceedings or pending malpractice actions? Judgments or settlements?	<b>NO</b>	<b>YES</b>
3. Ever been suspended or had his/her privileges restricted or terminated?	<b>NO</b>	<b>YES</b>
4. Ever been denied a certificate of completion of training for any reason?	<b>NO</b>	<b>YES</b>
5. Ever resigned or withdrawn his/her association with your program to avoid the imposition of disciplinary measures?	<b>NO</b>	<b>YES</b>
6. Experienced health problems, either physical or mental, including substance abuse, which affected his/her performance in patient care?	<b>NO</b>	<b>YES</b>
7. Ever been convicted of a crime?	<b>NO</b>	<b>YES</b>

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**A YES to any of the above questions in this section should have an explanation ATTACHED.**

\_\_\_\_\_ YES, I agree to send to the University of Rochester program a final summative competency-based performance evaluation as well as a listing of rotations completed and procedure/operative experience record (if applicable) for this training year by July 31<sup>st</sup>.

Printed Name of Program Director: \_\_\_\_\_

Current Program Director Signature: \_\_\_\_\_

Date: \_\_\_\_\_