



Nellis Family Medicine
Privileged to Serve Air Force Families

FACULTY HANDBOOK

June 2012

INTRODUCTION

Welcome to the Nellis Family Medicine Residency (FMR). You are a member of the newest AF Family Medicine training program. Our residency achieved initial accreditation and opened in 2009. We provide full-spectrum Family Medicine within our clinic, and many providers have their own niches where they can thrive. I trust that the unique talents which you bring with you to this assignment will contribute to the further excellence of this program.

In this electronic handbook you will find a review of the credentials and requirements for faculty members, detailed guidelines as to the faculty responsibilities, individual patient responsibilities, administrative responsibilities, and a discussion of the faculty development.

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PROGRAM GOALS AND OBJECTIVES

1. **Mission:** The mission of the Nellis Family Medicine Residency is to provide world class instruction so graduate physicians can supply a personal medical home for patients from cradle-to-grave, whether deployed or in garrison.

2. **Goals:**

To produce COMPETENT and QUALIFIED physicians:

The primary goal of the program is to produce highly qualified, board-eligible family physicians capable of providing continuing and comprehensive care to the individual and family as an integrated unit, in any military or civilian medical system. Graduates are capable of independent practice in the field of Family Medicine and recognize that our responsibility is not limited by sex, age, organ system, or disease process but is comprehensive delivery of medical care.

To propagate our specialty through MENTORING:

The program should cultivate mentors who particularly focus on medical students learning our specialty while helping them foster skills unique to Family Medicine that they can use in their future specialty. All instruction is performed in an environment that places the highest priority on patient safety and empathic care.

To perform as LEADERS:

Graduates will lead patient care and be able to assume responsibility for directing a team approach to health management. Emphasis will be placed on the integration of a body, mind, and spirit approach as well as promoting healthy family dynamics within the broad context of community health care. The goal is learning how to engage patients and help them utilize their resources to cope with an illness and injury.

3. **Objectives:**

Founded in the ACGME core competencies and The Future of Family Medicine: A Collaborative Project of the Family Medicine Community

- a. Precepting family physicians to create a broad-spectrum, *patient-centered medical home* which results in generative growth for each individual patient and family
- b. Promoting *patient ownership* of all military families enrolled to the panels of the Family Medicine Residency through continuous on-going relationships in the outpatient, inpatient and nursing home settings.
- c. Supervising through *mentoring relationships* with team chiefs, fellow residents, and medical students to support the individual and the specialty of Family Medicine
- d. Preparing residents to gain sufficient medical knowledge to *pass examination* by the American Board of Family Medicine
- e. Requiring *scholarly activity* and encouraging active participation in organizations which further life-long learning such as AAFP (American Academy of Family Physicians) and USAFP (Uniformed Services Academy of Family Physicians)
- f. Creating a *conducive atmosphere* for academic, emotional and spiritual growth of the entire staff by balancing time spent between medicine and family life; supporting weekly Balint meetings for morale and stress relief as well as providing clear policies regarding resident fatigue.

- g. Teaching family physicians to become educators of patients, their fellow health care workers, as well as curious, self-directed learners for their own identified needs; clinical curiosity is paramount.
- h. Supporting community and international medical experiences including civilian and military humanitarian missions
- i. Enriching resident and staff experiences by partnering with civilian medical resources at Sunrise hospital, University Medical Center, the VA, Silver Hills Health Care Center, and local physician offices.
- j. Developing ethical physicians who consistently display professionalism and integrity, as they humanize the health care experience in the family context of problems.
- k. Incorporating evidence-based medicine (EBM) concepts into their practice and self-directed learning to develop a natural command of medical complexity
- l. Promoting cost-effective health care maintenance and disease prevention at all stages of the individual and family life cycle.
- m. Learning key military medicine concepts of the USAF medical service such as readiness, family health initiative (FHI), use of physician extenders and expeditionary medicine.
- n. Leading nurses, technicians, and other ancillary staff in interdisciplinary team work, as they handle stressful situations, deal with ambiguity, and interact with the system around them.
- o. Leveraging electronic records (AHLTA) and population health information technology resources to document clear concise notes, code accurately to allow appropriate billing, and target health care delivery to high-risk disease management diagnoses.
- p. Organize, interpret and advocate for the patient's needs when coordinating consultant care for empanelled patients

4. Assessment of Goals & Objectives:

A 3 year program of advancing responsibility, privileges and independence has been developed. This program emphasizes inpatient medicine, block rotations, and weekly Family Medicine clinic in the PGY 1 year and supervisory experience with subspecialty/elective focus, longitudinal format and continuity OB/emergency medicine in the PGY 2 and PGY 3 years. Increasing emphasis is placed on ambulatory rotations as the resident progresses. Evaluation by peers, Family Medicine faculty and faculty from outside departments is used not only as an educational formative feedback tool, but also as a summative means of documenting the resident's progress towards staff level competence. Evaluation also serves to identify those residents who are in need of special assistance or remediation. National in-service training examinations and Family Medicine board examinations provide further documentation of performance relative to Family Medicine peers in other residency programs.

The residency environment includes a continuously evolving curriculum experience, which is under constant evaluation; evaluation informs curriculum to complete the residency assessment process. Residents are guided by monthly team chief sessions to monitor acquisition of appropriate knowledge, skills, attitudes, performance, and practical experience. As a group, the faculty discuss each resident's performance quarterly and provide feedback to the team chief to take back to the resident.

E*Value is our web based system to collect formative and summative evaluations, including 360 evals from peers, patients and ancillary staff. Every quarter, the faculty reviews every resident's progress as reported by their team chief/advisor. Every 6 mos, an Air Force form 494 is completed on each resident to satisfy by AF regulations and ACGME requirements.

Additionally, every 12 mos an AF Form 475 narrative training report is composed which summarizes performance and is used later for consideration of promotion to a higher officer rank. The faculty also account for In-Training Exam performance when making decisions for adding progressive responsibility. Specifically by year group the **MILESTONE ACADEMIC PROMOTION criteria** are as follows:

5. PGY1 to PGY2 (includes supervisory role)- pass all rotations, maintain ACLS/BLS/PALS/NRP, pass Step 3, collective staff opinion that resident has sufficiently grown as a clinician to begin supervision of new interns.
6. PGY2 to PGY3 - pass all rotations, maintain ACLS/BLS/PALS/NRP, obtain state medical license, have scholarly activity project approved, show real progress towards completion of scholarly project
7. PGY3 to Graduation - pass all rotations, maintain ACLS/BLS/PALS/NRP, take Board Certification exam, complete scholarly activity project, complete 10+ continuity OB deliveries and 40+ deliveries overall, complete 1650+ outpatient FM center visits

SCOPE OF SERVICES
FAMILY MEDICINE SERVICES

TYPES AND AGES OF PATIENTS SERVED:

1. Types of patients served in the Family Medicine Clinic include but are not limited to:
 - a. Adolescents (from age 13), adult, and geriatric patients requiring ambulatory care such as self-limiting acute and chronic illnesses, physical examinations, health/wellness education, a limited number of minor surgical procedures, preventive medicine, general medicine, obstetrics and women's health, and coordination and referral of clients requiring specialty services.
 - b. Pediatrics (newborn to age 12) requiring general pediatric care to include well-baby exams, preventive medicine, physical exams, chronic and acute medical problems.
 - c. Application of technologies such as infusion therapy, patient/family education, pain management, minor surgical procedures, skin biopsies, vasectomies, nebulizer therapy, exercise stress tests, ear irrigations, colonoscopy, colposcopy, LEEP, obstetrics and gynecological procedures, OMT, acupuncture, and orthopedic measures such as slings, splints and casting.

APPROPRIATENESS, CLINICAL NECESSITY, AND TIMELINESS OF SUPPORT SERVICES:

1. Appropriateness: Care is continuously evaluated by all health team members through a process improvement program consisting of review of medical records, documentation, and patient outcome evaluation as well as satisfaction survey.
2. Clinical Necessity:
 - a. Metrics are designed to monitor access for the enrolled population according to pre-established TRICARE standards.
 - b. Ongoing peer review assures appropriate treatment, follow-up, and referral.
3. Timeliness:
 - a. Care is provided from 0700-1600, Monday through Friday
 - b. Acute same day appointments are available when the clinic is open.
 - c. Telephone consult, Relay Health (MiCare) and follow-up is also used to access Primary Care Manager; All physicians should make DAILY effort to return messages and then document said effort electronically.
 - d. Community and network resources are utilized to provide timely interventions when demands exceed availability.

AVAILABILITY, KNOWLEDGE AND SKILL OF NECESSARY STAFF:

4. Knowledge required:
 - a. Completion of an ACGME certified Family Medicine residency with inpatient, outpatient and procedural expertise. OB care performance is required.
 - b. All medical providers meet credentials requirements of the organization.

STAFF CREDENTIALS

1. You are required to keep an updated and cumulative record of your continuing medical education activities. The Air Force requires that you obtain 150 hours of continuing medical education over a 3-year period. The AAFP has an excellent CME tracker on their web site. Remember annual maintenance of certifications are required by the AAFP.

<http://www.aafp.org/online/en/home/cme/boardreview.html?navid=maintain+your+certification>

2. The Air Force provides one funded (local/AFIT) TDY for CME per year, plus local approval is usually granted for one permissive (non-funded) TDY per year. Staff is strongly encouraged to utilize AFIT, since this reduces the financial burden on our hospital. Applications for funding should be submitted early in the fiscal year – watch for emails from the SGH.

3. The Air Force requires you to have an unrestricted state medical license.

4. FMR requires its faculty members to have and maintain board certification.

5. As a FM faculty member you are required to be current in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Neonatal Resuscitation Program (NRP). You are strongly encouraged to obtain Advanced Life Support in Obstetrics (ALSO). All of these provider courses (except ATLS) are offered here at Nellis.

6. This faculty handbook will serve as your written job description while you are a member in this department.

COMMITTEES

1. All physicians are required to participate in the hospital committees. These are assigned by the Program Director; volunteers are appreciated. Staff participates in these committees for at least one year's time. The entire list of committees is tracked on the annual FMR faculty assignment list.



CLINIC RESPONSIBILITIES

1. All Core faculty are assigned a panel of approximately 350 patients; These patients are selected so that you get an adequate mix of age groups as well as disease processes. Though panel profiles vary, we make an attempt to have panels consist of a set amount of Pediatrics, Obstetrics, active duty, and geriatric patients. See our clinic Group Practice Manager (GPM) or log onto your Care Point to receive a computer-generated list of your patients.
https://carepointsuite.nellis.af.mil/portal/portal_login.aspx
2. Faculty will typically have two to three half days of continuity clinic per week to see your empanelled patients. Routine and acute appointments will be scheduled at 15-30 minute intervals. Minor surgical procedures may be scheduled for 30-minute appointments.
3. The monthly clinic schedule is produced by the Director of Operations and the Chief Residents with the Flight Commander providing oversight. Leave MUST be coordinated 2 months in advance. The leave form (AF 988) is electronic and must be used via LeaveWeb on the MOFH web site. LeaveWeb should be completed 3-14 days prior to departure. Permissive TDY forms must be signed by the squadron commander, not the Program Director. Electronic leave forms are signed by your supervisor. The first signature on regular TDY forms should also be the Program Director.
4. Should you require a change in your clinic schedule, you must obtain the approval of the Director of Operations who will notify the scheduling personnel. Since our appointments are opened 4 to 6 weeks out, it is important to make this notification as soon as possible. Schedule changes may only be approved by the Clinic Chief or Flight Commander. You should have no expectation of cancelling appointments without significant justification.
5. Should you require an unexpected or last minute change in your clinic schedule, please attempt to negotiate coverage with a fellow staff physician, if possible. If not, discuss the cancellation/rescheduling of your clinic with the Director of Operations.
6. We use AHLTA as our exclusive outpatient medical record. All encounters must be complete and signed off within 24 hours of the appointment time.
7. The SOAPP format will be used for documenting all patient encounters. This is the Air Force standard. Documentation of thought process and treatment goals in the A/P must be used for excellent patient care as well as modeling for the residents. Synchronicity and structure is strongly encouraged.
http://www.aafp.org/fpm/2011/0700/p15.html?aafpvlogin=7245209&aafpvpw=&URL_success=http%3A%2F%2Fwww.aafp.org%2Ffpm%2F2011%2F0700%2Fp15.html
8. Unless down for technical reasons, physicians are expected to document all outpatient encounters in AHLTA. Paper records will not be kept. Essentris EMR is required use for inpatient notes.
9. Dictation is available for use when completing MEBs and H&P's. See Inpatient Records for instructions and a code. Dragon Voice Recognition software is also available by the facility, pending the current number of unused MDG licenses.

LECTURES, EXAMS, AND SEMINARS

1. Morning Family Medicine Lectures: 0715 in the Lecture Hall. Topics and speakers are assigned by the morning lecture coordinator. Faculty are expected to provide 10-12 of these 40-minute talks each year. Unless performing urgent patient care related duties, **you are expected to attend the morning sessions which are part of the duty day.** At present, we have group PT every other Friday am. The 1st Thursday of each month is usually SQ CC call; ProStaff is the 4th Thursday of each month – both at 0700 start.
2. Noon Lectures:
 - a. 1-2 times per week in the Lecture Hall. Topics and speakers are coordinated by the chief resident and curriculum coordinator. Faculty are expected to provide 1-2 (45-minute) presentations per year. Faculty are encouraged to attend as many noon conferences as possible to support resident attendance.
 - b. Other noon conferences may include Grand Rounds, Journal Club, Resident Council, Resident/Staff and clinic meetings. Consider Resident/Staff and Journal Club as MANDATORY events on your calendar, superseded only by immediate patient care needs.
3. In-Training Exam: A **required** annual exam given nationwide to all Family Medicine residents in late October or early November. Residents must be off-service from 2000 hours the night before the exam until 1300 following the exam. Staff attendings will cover the services.
4. USMLE or COMLEX Step III: A **required** exam, given once nationwide to all PG1s must be taken by 31 March.
5. Resident Annual Review: An annual review of the residency curriculum is held each year in May on the second Friday. Attendance is **required by all residents and staff**. The retreat is typically held at a site off location from 0800-1600 on Friday and 0800-1200 on Saturday. Residents are considered off-service during these hours, but must coordinate with each individual service.
6. Graduation Banquet: An annual banquet for Family Medicine residents is held in late June, typically the last Saturday night of the month. Attendance is **required by all residents and Staff**. The banquet is usually held on a Friday or Saturday evening and residents should be considered off-service from 1500 that day until 0800 the next morning. Staff attendings will cover the services.
7. Graduation Ceremony: The annual graduation ceremony that typically occurs on the morning of 30 Jun (unless this falls on a weekend, then it will occur on the closest weekday). **Attendance is required by all PG1 and PG3 residents and Staff**. Residents are considered off-service from 0800-1300 that day. PG2 residents will remain on-service during the ceremony. Staff attendings will cover the services for inpt needs.
8. There are other times when residents will be absent from clinic or ward rotations on a recurring basis.
 - a. Balint: Each residency year group will meet once a week in a group setting. These balint groups are moderated by the FMR behavioral medicine specialist. They are designed to help residents cope with the stressors of residency while maturing into a family physician and teach behavioral medicine concepts. Attendance at these meetings is **mandatory**. Residents are not to be interrupted for any reason except for true patient emergencies or continuity OB deliveries.

b. Training Days: The second Thursday of each month a readiness lecture and/or training will given from 0700-1200. Attendance is **required by all residents and staff, except for staff covering inpatient duties.**

9. . Research Symposium: The Wednesday before graduation. **Attendance is required.**

MEDICAL STUDENTS

1. Third-year medical students from USUHS and Touro University-Nevada rotate on Family Medicine clerkships on a regular basis throughout the year. In addition, fourth-year USUHS students return for electives and third- and fourth-year HPSP students come periodically for one-month electives in Family Medicine. All students will participate in several of faculty clinics over the course of their rotation; they may also be assigned to one week on the inpatient service during their elective.

2. Medical student responsibilities include:

a. Patient evaluations, in which they may see the patient individually, initially, or with their assigned physician for that clinic, at the discretion of the physician. All patients who are seen by students must be evaluated by that assigned physician.

b. Students may write notes in the outpatient record, which must be taken over in AHLTA by the physician who also evaluated the patient.

c. Students may write History and Physicals with staff take over in AHLTA.

d. Students may not write official progress notes on inpatient records, but you can take over their notes in AHLTA.

e. Students may participate as a first or second assist in minor surgeries in the clinic.

f. Students may perform minor procedures only with direct supervision of a credentialed physician.

3. All staff will evaluate each medical student after each clinic and provide these evaluations to the Predoctoral Coordinator using the standard clinic RIME form.

4. Please refer to the more defined description of the Family Medicine clerkships and evaluation forms as maintained in the USUHS Family Medicine Clerkship Handbook.

5. Students are expected to take call as determined by the undergraduate coordinator.

6. Students also have the opportunity to be videotaped during their rotation to provide them feedback on interviewing skills.

7. Students will each give a 15 or 30 minute presentation as part of the morning lecture series on the topic of their choice.

8. Just prior to leaving, each student is briefly interviewed and photographed, to be filed for future reference when evaluating potential resident applications.

DEPARTMENT LIAISON

1. Staff members will be assigned as interdepartmental liaisons for the majority of the other specialties. The liaison will function as the primary contact for communication with that department and the Family Medicine faculty. These communications will include:
 - a. Family Medicine-generated inquiries and discussions regarding any resident problems or issues related to that department.
 - b. Any curriculum, evaluation, or scheduling problems.
 - c. Any proposed policy changes or inquiries.
2. The liaison may attend monthly departmental meetings and should consider periodically attending that specialty's morning rounds and/or check out rounds, etc., especially if particular resident issues or problems are being evaluated.
3. You should expect to be assigned as liaison to several departments.

DAILY CLINIC ROUNDS

1. Morning Rounds. All faculty, third-year FM residents (PG3), PG-1 and PG-2 residents assigned to rotations without morning report and medical students are expected to participate in FM Morning Rounds (Monday, Tues, and Thursday at 0715 in the Lecture Hall). Group PT is held some Fridays at O Dark Thirty.
2. You are expected to attend Morning Report and PT at all times.
3. You will be asked to give some of the 40 minute lectures at Morning Report. These lecture topics satisfy a large portion of our 3-year didactic curriculum. Morning report is to be facilitated by the Chief Resident(s).
4. Closing ("Check Out") Rounds--Held @ 1630 for the Inpatient Team to sign out to the night on-call staff. These checkout rounds satisfy the criteria set forth by the commander for patient hand-offs.

CONSULTING

1. You will be scheduled to precept the residents in clinic typically one to four times each week. You are expected to be available in the consultant room when assigned as the consult doc. Your responsibilities will include the following:

a. Assist the residents with questions and evaluations of patients and CHCS/AHLTA order entry/data retrieval. Feedback should be balanced between positive comments and areas of improvement. The resident should be encouraged to think through the issues rather than just given the answers. These interactions will be dictated by the level of the resident's training and the time constraints of the clinic. The 1 minute precept model is highly encouraged.

<http://www.stfm.org/fmhub/fm2003/jun03/stevens.pdf>.

b. Chart review of resident notes (see guidelines below).

c. Staff any minor surgery procedures/OB ultrasounds by the residents as needed.

d. Primary liaison for the nursing staff for any immediate clinic problems, emergency refills, urgent walk-ins, inspection of wound repacking, etc.

e. If so designated, to precept/staff the resident's special clinics (i.e. vasectomies, colonoscopies, GXTs, minor surgeries, or colposcopies).

f. The second consultant may occasionally be required to see walk-in acute patients. The second consultant will be responsible for care and supervision of Family Medicine patients on the Obstetrical unit when the primary attending is overtaxed or not credentialed.

g. Cross-cover residents and staff who are called away from their scheduled clinic (i.e., delivery or family emergency).

2. Guidelines for Chart Reviews are as follows:

a. All resident physicians will have charts reviewed from each clinic:

PG1: Until mid-year all patients precepted and charts reviewed. After midyear all charts are still reviewed but face-to-face precepting is not required.

PG2: all charts per clinic

PG3: all charts per clinic.

Staff Reviewed: handled separately

****All OB charts will be reviewed for staff and residents.**

- Any time you are consult clinic doc, the expectation is you will log into EValue and complete at least one chart review per resident in clinic. If the notes are all perfect, then say so. If they can be better, please record how. This is a reportable item to the Exec Staff.

b. These charts are reviewed in depth to assess for adequate documentation, differential diagnosis, management plans, completion of SOAP-P format notes and the Problem List. The preceptor will cosign in AHLTA. Feedback forms are in E*Value and will be used to give positive or corrective comments to the residents.

c. Staff chart review will be annotated in the Staff Peer Review log for tracking for QI purposes.

d. The residents will send notes to the Consult Doc in the Con room who is assigned to the session. However, if they are not completed during clinic hours (before 1230hrs for AM Clinic or before 1630hrs for PM Clinic) then they will send notes once finished to the FMR On-Call attending for that evening. Therefore, if the on-call attending has cosigns from the day, staff will input an E*Value CONCERN CARD to monitor trends/progress. This system prevents notes being sent for cosignature when the faculty has left for LV or TDY; all visits must be closed out within 72 hrs for reimbursement requirements.

READINESS and MOBILITY

1. The staff of our Family Medicine Residency Program fully supports the 99 MDG's readiness, mobility and disaster-preparedness missions. This may include full participation in exercises, training and the regular deployment of 1-3 of our staff members.
2. Readiness training takes place the second Thursday of each month. The lectures, exercises and other training are mandatory formations for the Family Medicine staff.
3. Hospital Disaster Preparedness: exercises are typically instituted annually. During all disaster exercises and recalls, the Family Medicine personnel will sign in (Admin area usually), then report to the Family Medicine Clinic or designated rally point.
4. During real-life natural disasters, physicians will likely be recalled to the medical facility to be available to attend any potential casualties and also to man outlying shelters. Family members will not typically accompany hospital personnel to the hospital for shelter.
5. Staff physicians may be allowed to attend Combat Casualty Care (C-4) Course if they have not previously attended.
6. It is your responsibility to remain current in all readiness training. Readiness will usually work with providers to schedule classes well in advance of the clinic schedule being booked. Please ensure our clinic NCOIC has your contact emerg contact info for the recall roster AND that you have a copy on your phone you can access at any time.

TEAM CHIEF RESPONSIBILITIES

General responsibilities include:

1. Monthly Resident Meetings. The Family Medicine Residency is organized into teams/elements for administrative purposes and to allow the team chief to act as individual liaison/mentor/counselor/supervisor to residents assigned. The team chief is responsible for meeting with each of their assigned residents on a monthly basis throughout the academic year. Meeting times will occur during one of the Monday AM sessions from 0715-0800. Consider occasional meetings off-site for lunch to enhance "esprit de corps". Documentation should occur monthly on the team chief DASHBOARD which each Staff keeps in their personal folder.



Team Chief
Dashboard Sample.xls

- Review monthly each resident's rotation/evaluation folder (www.e-value.net) and share the feedback with the resident. Positive feedback is especially encouraged. Review previous evaluations on the resident looking for specific areas of strengths/potential weaknesses. This will help residents set goals for upcoming rotations. Other possible topics to review:
 - Discussion of goals/objectives form for upcoming rotation (found on G:drive) and any special circumstances surrounding it.
 - Discussion of Family Medicine clinic work; progress, problems, improvements, outpatient charts, checkout rounds, feedback from Family Medicine staff.
 - Discussion of Step exams, Licensure, Life support currency
 - Discussion of adequacy of patient load and mix, and efficiency for seeing patients in appointment template time allotted.
 - Discussion of reading time and ability to stay current with medical literature.
 - Discussion of extracurricular projects and interest.
 - Discussion of 360feedback from clinic nurse and patients.
 - Discussion of impact of residency on home life and personal growth goals.
 - Review of plans/progress of scholarly activity projects(s) required for graduation.
 - Guide choice of electives.
 - Check on procedure and patient diagnosis documentation for credentialing.

2. RDW (Residency Development Workshop) Review. The team chief will conduct a quarterly resident folder review for presentation to the faculty during RDW. The residency coordinator will notify you via email when your resident is due for presentation. Please be ready or make

notification prior to RDW if you cannot attend and present.

3. Team Meetings. In order to foster team cohesiveness, the entire staff and resident team along with the nurse and techs should meet for huddles as directed by the Element Leaders. Current workflow issues, team communication and ideas for improvement should be reviewed. The Flight Commander should also provide a monthly topic to review.

4. Administrative Duties.

a. Administrative coordinator for each assigned resident (promotion recommendations/PRFs, training remediation plans and disciplinary actions).

b. Completion of annual officer training records. Complete one on each assigned resident by 1 June. Available on <http://www.e-publishing.af.mil/>: Education/Training Report (AF Form 475) and Academic/Clinical Evaluation Report (AF Form 494). The residents should assist in providing bullets for the AF 475. In particular, the PG3s should attempt to write their own bullets with the team chiefs providing feedback. It will typically be their first attempt at "bulletology" prior to graduating and supervising others. OF NOTE, the 494 must be completed every 6 months.

c. If a team chief is assigned over a chief resident, it is standard to accomplish an achievement medal write up. This should be given to the Program Director by 1 April. Please see the PD for samples.

d. Personal training, clinical duties, and other responsibilities. Faculty should never be on the delinquent list since we are the examples of professionalism that the residents aspire to.

TEAM CHIEF ADVERSE ACTIONS ADMINISTRATIVE RESPONSIBILITIES

1. Academic Notice or Probation:

a. Academic Notice is generated when resident performance signals concern and the resident is in danger of failing the rotation or several rotations. Academic Notice is written by the Team Chief and signed by the Program Director and must include specific statements regarding problems noted, suggestions for improvement, and specific time allowances for demonstrated correction of deficiencies.

b. Academic Probation must be approved by the Residency Education Oversight Group (REOG) upon recommendation by the Program Director. Inadequate performance and determination that the resident is in jeopardy of failing or delaying completion of that year level will be reported and monitored. The Academic Probation statement must include the deficiencies observed, specific expectations of performance, and time allowance for that improvement to be determined; failure to meet the defined expectations generally results in resignation or termination from the residency. AFPC, the DME, GMEC and state licensing board will be notified.

c. Letters of Admonishment/Letters of Counseling/Letters of Reprimand; these are written by the team chief as determined by the Program Director and faculty and must be signed by the Program Director; Letter of Reprimand must be elevated for the Commander's signature and direct counseling of the resident. All "Due Process" actions will be closely supervised by the Program Director in accordance with the MOFHI and AFI-41-117, Section 2.2.

WARD ATTENDING

1. Each physician faculty member will rotate as the ward "Attending" to provide teaching support to the residents on the Inpatient Service (Family Medicine, Flight Medicine and unempanelled patients). Responsibilities for your week include:

a. Admissions:

(1) All ICU criteria admissions will be seen and evaluated promptly (**within 1 hours or sooner**) by the staff attending.

(2) All other admissions must be discussed with the staff attending upon admission and must be evaluated in person by the attending (or senior resident on night float) in a timely manner (**within 8 hours**) and an admission note written.

(3) The on call Family Medicine provider will staff any FMR OB patients on the labor deck, besides covering the MSU/ICU. When the staff attending does not deliver babies, there will be another physician assigned this responsibility.

(4) The FM staff attending will act as a consultant to the surgical services when consulted.

(5) The attending will assure resident progress notes are written daily (twice daily on ICU patients). If the attending does not write their own daily SOAP note, then a statement must be written by the attending daily attesting to the fact that they have 1) seen and examined the patient, 2) discussed the mgt plan with the team, and 3) agree with the plan as documented by the house staff. Essentris makes this task easy. If you do not include all 3 components when you co-sign the note, then the inpatient coders cannot count the "RWP" workload by the team for that day; RWP reimbursement drives manning and budgets!!!

(8) The weekly FM ward attending will write the staff admission note on all routine, uncomplicated admissions occurring between 1630-0700 that were not directly evaluated by the on-call staff physician, if the on-call physician was unable to complete the note. The ward attending will similarly be responsible for reviewing the admission history and physical of the admitting resident and cosigning; all H&Ps written or dictated by residents require staff co-signature.

b. Call.

(1) Staff attending covers "day" call (0700-1630, M-F) for the Family Medicine Team, as well as weekend call (Friday 0700 thru Saturday at 0700 and Sunday 0700 to Monday at 0700), while on service. Another staff will cover call 1630-0700 hrs on Mon-Thurs nights.

(2) The night call staff will come in for complicated, obstetric or ICU patients and complete staff notes to allow for prompt medical oversight.

(3) Weekend and holiday FM team round times are negotiated between the on-call staff and residents but typically occurs @ 0800.

c. Consults.

(1) Any inpatient consults to the Family Medicine team will be addressed by the resident and discussed with the FM staff. All resident consult notes must be cosigned by the FM staff.

2. Continuity. Your patients expect to see you when they are hospitalized. However, the day-to-day care is managed by the inpatient team. To meet RRC requirements, the continuity resident must be involved in the decision making, consultation, and discharge planning and write a brief 1-2 line note in the chart daily.

When a patient is admitted, the on-call inpatient resident should explain to the patient how our inpatient team care works, i.e., that a team of doctors will be seeing the patient and that the primary doctor will be informed that patient is in, and that follow-up care will be provided through the primary provider.

RESIDENT EVALUATIONS PROCEDURES FOR TRACKING/FILING

The FMR Program Coordinator will track and file all evaluations via E*Value.

a. Our coordinator will send an electronic copy of the goals and objectives prior to the upcoming rotation. The staff attending(s) will receive e-mail notice to complete the orientation evaluations. The rotation evaluations will be forwarded to the resident electronically for review or comment, then on to the PD for review and electronic filing.

b. Senior residents on the inpatient team are to evaluate their interns.

c. The program coordinator will track evaluations. Team chiefs can check for incomplete evaluations on E*Value. It is ultimately a resident and team chief responsibility to assure evaluations are completed.

d. Rotations are considered incomplete until the evals are returned. Incomplete rotations must be made up before TDYs, leave or progression to the next year of training. Up to half of total elective can be used for make-up rotations.



Nellis Family Medicine Residency

Obstetrics Policy

Continuity OB Patients

1. Each resident will receive approximately two continuity OB patients per month and each staff will receive approximately 5-6 continuity OB patients per year
 - a. New OB charts will be reviewed by an OB provider and given to Lynn Harvey for scheduling.
 - b. Only uncomplicated OB patients will be assigned to a FM resident or staff
 - c. Uncomplicated OB patients already empanelled under a resident or staff will likely remain under that provider until the above requirement is met
 - d. Residents and staff will be responsible for ensuring new OB patients assigned to them are seen for their first OB visit in a timely fashion (within 1-2 wks of being notified) as well as routine antepartum visits – this may require walk-in appts. Lynn Harvey may assist in coordinating the appts with the patient and provider.
 - e. Patients with positive screening for anxiety/depression will be contacted by the continuity physician ASAP to determine need for immediate BHOP referral/treatment prior to new OB visit if over a week till that visit.
 - f. Those patients who request a particular provider may be assigned to that provider only after approval is obtained from the FM/OB Director. Residents should not guarantee a patient that they will see a particular doctor in FMR.
 - g. The above number of continuity OB patients assigned to residents and staff will allow current and future RRC requirements to be met, as well as the ability for FM faculty to obtain an adequate number of deliveries to maintain currency (strive to perform ≥ 10 deliveries/yr).
2. **All** residents will precept each OB visit with the CON doc **PRIOR** to the patient leaving the clinic.
 - a. The visit flow sheet, lab sheet, problem list, ultrasound photos and AHLTA note **MUST** be completed at the time the patient is presented to the CON doc.
 - b. The resident will directly hand the chart to the CON doc during the presentation to allow close review.
3. Once the CON doc has precepted the patient, any necessary adjustments of the plan will be discussed with the patient **before** leaving the clinic and the chart will be placed back in the CON room, in the “Second Sign” rack, for further review. OB charts will **NEVER** be placed in the CON room or on a faculty desk after 1600 – this will be **strictly** enforced!
4. All residents performing first trimester ultrasounds **MUST** have staff in the room. All other ultrasounds performed by PGY1s in clinic on continuity OB patients **MUST** have staff (usually

the CON doc) in the room. PGY2s and PGY3s do not have to have staff present in the room; however, if there is any question as to the findings or calculations/measurements, the staff should be present. Documentation of all ultrasounds performed in clinic **MUST ALWAYS** include photos and notations in the AHLTA note.

5. FM faculty (including FHC providers) should also ensure fully completed OB charts are placed in the “Second Sign” rack for further review by 1600 on the day of the visit.
6. Residents who are not available (i.e. on leave, TDY, or outside the immediate area only) to care for their continuity OB patients **MUST** designate a surrogate **AND** clearly document this on the chart (post-it note, etc) as well as on the Labor deck on-call board. This surrogate must be a resident that is **NOT** on an outside rotation and hence available to care for the patient during all hours. Team chiefs need to ensure a surrogate has been designated before leave/TDY is taken.
7. Those continuity OB patients that develop a high-risk condition will be managed accordingly:
 - a. Either the patient will be transferred from the original resident/staff’s panel to the FM/OB panel as the primary provider or,
 - b. Will be transferred to the WHC as the primary provider
 - c. Uncomplicated patients with potential high-risk conditions may need a one-time consultation with OB or FMR/OB vs. complete transfer of care to WHC. Conditions requiring either consultation or transfer are outlined by the attached file.
 - d. If a patient is transferred to the FM/OB panel, every effort will be made to allow the resident a small portion of continuity and delivery so as to allow credit for the continuity, if the resident so chooses.
8. The FM/OB provider will attend all HROB meetings on the first and third Wednesday of each month. If the FM/OB provider is not able to attend, a surrogate will be appointed.

Labor and Delivery Unit

General:

1. Faculty will continue to serve as the primary L&D provider on Tuesdays and Wednesdays. FHC providers may schedule L&D shifts with the OB department directly.
2. During daytime shifts the faculty is expected to remain on the L&D floor if any patient is in labor. (Brief runs to cafeteria, etc are permitted, but the faculty should always be readily available).
3. If the assigned FM faculty is not able to cover a portion or the entire shift, a replacement within FMR should be sought before approaching the OB department.
4. For the sake of patient safety, FM faculty on-call who are unable to adequately monitor and manage L&D patients due to a high volume or acuity of medicine/OB patients **MUST** notify

the back-up FM provider for assistance. This action should never be viewed as incompetence or weakness, and no retribution will result.

5. The FM faculty will review, on a quarterly basis, the workload and demands of FM providers on-call and subsequently make adjustments to minimize potential patient overload and safety concerns.
6. If the L&D nursing staff is unable to contact the FM faculty on-call, or is uncomfortable with the management of patients after discussion with the FM faculty, the L&D staff may contact the FM/OB or OB backup provider. The FM/OB or OB backup provider schedule will be posted on AMION.

Admitted/Laboring Patients:

1. The FM faculty staffing L&D on Tues. and Wed. will attend morning report on the following day to review the patients under their care from the previous day unless prohibited by clinic schedule. This is intended as a peer review and learning opportunity for ALL providers present.
2. While labor management styles differ at times between FM and OB providers, accepted community and DoD standards of care must be met. To facilitate active labor management, each morning report/check-out will include an outline of expected milestones and treatments anticipated for each laboring patient, discussed between the FM faculty and OB or FM/OB backup, to ensure a clear plan is established. Periodic reviews of the plan and current progress are highly encouraged throughout the shift to ensure timely management occurs. Open and clear communication, in the TeamSTEPPS format, is paramount.
3. The criteria for FM/OB or OB notification or presence during the labor and/or delivery process are outlined in the attached file.
4. Per RRC regulations, all resident notes (antepartum, intrapartum and postpartum) must be reviewed and cosigned by the attending staff (FM, OB or Midwife).
5. A PGY2 or PGY3 resident will not independently supervise a PGY1 performing a delivery – FM or OB faculty ***must*** be present.
6. In accordance with RRC regulations, a maximum of a PGY1, one upper level resident and staff may be present at a delivery and each be able to count as a performed delivery.
7. FM and OB faculty are expected to perform confirmatory cervical checks following the PGY1s for all unruptured induction or laboring patients. Strongly consider performing the same when precepting PGY2s and PGY3s.

Triage Patients:

1. When a resident's continuity OB patient presents to triage:
 - a. If the patient is 36 0/7 wks and greater, the nurse may perform the initial evaluation and contact the resident directly. The resident will then contact the FM staff on call and discuss the case. The staff will then decide if the resident will personally evaluate

their continuity OB patient or discharge home. The staff will then contact the L&D nurse to discuss the plan. This is meant to foster and reinforce the sense of patient ownership and dedication. If the primary resident is not available (i.e. on leave, TDY, or outside the immediate area only), the designated surrogate should be contacted and, if needed, evaluate the patient.

- b. If the patient is 35 6/7 wks or less, the resident is required to personally evaluate the patient, contact the FM staff on call and discuss the case. The L&D nurse should not perform the initial evaluation, unless they deem the patient an emergent situation as a bridge to physician evaluation. Whether the FM faculty needs to evaluate the patient in person is at the discretion of the FM faculty.
2. Residents must personally evaluate a triage patient within 1 hour of being called by nursing staff.
3. PGY1s must have FM faculty present to evaluate patients.
4. PGY2s and PGY3s may evaluate OB triage patients independently, and precept the patient either in person or via phone. The FM faculty **MUST** cosign the Essentris note as soon as possible.
5. Faculty are not required to always personally evaluate their continuity OB triage patients; however, deference should be given to nursing/L&D staff who deem the clinical presentation of high enough acuity to warrant personal evaluation. This means that if the patient is in threatened PTL, vaginal bleeding, etc., or the nursing staff says “I am not comfortable” the staff **MUST** come and evaluate the patient.
6. All triage notes will be documented in Essentris – be sure to include a description and an appropriate assessment of the fetal heart tracing (e.g. Category I – reassuring). Faculty must document triage notes in Essentris whether or not they personally evaluated the patient.
7. When evaluating a late preterm (34 0/7 to 35 6/7 wks) triage patient, faculty and residents are highly encouraged to consult the FM/OB or OB provider on call to ensure the highest standard of care/patient safety is met.
8. When evaluating an early preterm (33 6/7 wks or less) triage patient, faculty and residents **MUST** consult the FM/OB or OB provider on call to ensure the highest standard of care/patient safety is met.

MANAGEMENT OF COMPLICATED OBSTETRICAL PATIENTS BY FM/CNM PROVIDERS:

1. This document is a set of working guidelines to ensure that the highest level of communication, collaboration, consultation and referral is achieved among the certified midwives and the obstetricians at Nellis AF Base. Although this list is not all-inclusive, it offers a minimal standard by which the Nellis staff wishes to practice obstetrics.
2. The goal of these guidelines is to ensure that the FMR staff/ midwives and the obstetricians are working in conjunction to provide the safest environment for our patients while maximizing our resource.
3. The following conditions will be periodically reviewed by the FMR/OB and OB physicians to facilitate modifications.

- **Conditions Requiring Transfer of Care to FM/OB or OB:**

- GDM A2 and above
- Multiple Gestation
- PPROM <36 wks
- Hx of PTD <36 wks
- Recurrent preterm labor
- Persistent placenta previa ≥28 wks
- Chronic HTN on medications
- Mild/Severe pre-eclampsia
- Moderate persistent asthma and above
- PMH including autoimmune disease, severe renal/cardiac disease or hemoglobinopathy
- Trauma/MVA with major injuries
- RLTCs or C/S requiring conditions

- **Conditions Requiring One-time Consultation with FM/OB, OB or Perinatology/MFM:**

- Abnormal genetic screening
- AMA
- Mild intermittent asthma
- Chronic or gestational proteinuria (>300 mg/day)
- Duration 2nd stage labor >2 hrs, 3 hrs if epidural
- Fetal anomaly detected
- GDM A1
- IUFD
- Non-vertex position @ 36 wks
- Oligo- or Polyhydramnios
- Preterm contractions/labor – 1st episode
- Transfer of any OB patient to outside facility
- Epidural
- Induction/Augmentation of labor by any method

- **Conditions requiring informal FYI consultation, per DoD Guidance:**

- Non-reassuring FHT (repetitive late decelerations or moderate/severe variable decelerations, loss of variability, or bradycardia/tachycardia)
- Maternal temp ≥100.4
- Trauma/MVA with no major injuries
- Postpartum hemorrhage

- **Conditions which may be managed by the FMR/CNM without OB physician notification:**

- Spontaneous active labor

- Meconium stained fluid
- Patient requiring amnioinfusion
- **Other conditions requiring FMR/OB or OB physician involvement:**
 - Vacuum delivery (FMR/OB or OB physician must be notified prior to performing)
 - 3rd or 4th degree laceration



INDICATION	CNM independently manages	CNM co-manages with obstetrician	FMR independently manages	FMR co-manages with and notifies Credentialed C-Section Provider	OB or c-section provider is in-house and primary provider
Spontaneous Active Labor	X		X		
Meconium stained	X		X		
Amnioinfusion	X		X		
Pitocin		X		X	
Magnesium Sulfate		X		X	
Census > 3 active labor		X			
AROM <3 cm or <-1		X		X	
Non Reassuring Strip: late decel >3; >3 moderate decel <90 or lasting 30 seconds; fetal bradycardia (<110's x >10 min) or tachycardia (>160s x >10 min).		X		X	
Maternal temp >100.4		X	X		
Vaginal Bleeding		X	X		
PreTerm: requiring medication		X	X		
Oligo		X	X		
Poly		X	X		
Macrosomia 4000grams		X		X	
Epidural		X		X	
Mild Pre-Eclampsia		X		X	
Severe Pre-Eclampsia		X		X	
GDM requiring Insulin		X		X	
MVA/Trauma		X		X	
PP Hemorrhage		X		X	
Vacuum Extraction		X:doc notified prior		X:doc notified prior to	

		to placement		placement	
Severe Pre E with HELLP, renal dysfunction, or requiring IV anti-hypertensives				X	X
Fetal Demise		X: MD confirms demise		X: and second provider to confirm demise	
Hx Eclampsia					X
VBAC		X		X	X
Transfer out			X	X	X
MVA c Injury				X	X
Multiple Gestation					X
Placenta Previa-complete				X	X
Marginal Previa				X	X
3rd/4th/Cervical lac				X	X
C-Section Patients				X	X

SCHOLARLY ACTIVITY AND THE ACADEMIC ENVIRONMENT

Put simply and succinctly, all core faculty are expected to participate in and produce scholarly activity every 1-2 years.

Examples of scholarly activity include the following (see following page for more examples):

1. Clinical research published in peer-reviewed literature or presented as a presentation or poster at regional or national meeting.
2. Educational research published in peer-reviewed literature or presented as a presentation or poster at regional or national meeting.
3. FPIN Clinical Inquiry
4. Case report research published in peer-reviewed literature or presented as a presentation or poster at regional or national meeting
5. Presentation at USAFP or similar meeting.
6. Writing a textbook chapter, AAFP monograph, or review article.
7. Presentation of IRB-approved Quality Assurance/Performance Improvement project in peer-reviewed format.

A thriving academic environment is NOT just made up of research and scholarly activity. All of us are teachers, some of us are great administrators, and some are great clinician-teachers. As an example of an academic incentive plan from Loma Linda University, the next page shows the variety of activities that promote scholarship. While our faculty salary and days off are not contingent on your score, those who score higher are performing the activities that will probably result in bigger and better roles sooner. Take some time to examine the following table, and see where your gifts lie/what skills could be developed. As you can see, teaching and research are held in highest esteem while administrative duties are of less total value, but required.



**FAMILY MEDICINE RESIDENCY ACADEMIC INCENTIVE PLAN
SAMPLE**

Physician:

TEACHING				RESEARCH					
	Relative Value	Time Spent (hours)	Number Done	Total Activity Score		Relative Value	Time Spent (hours)	Number Done	Total Activity Score
CLASSROOM TEACHING				PUBLICATIONS					
Noon Conf or Fac Dev-New	5	15	-	-	Abstract Published 1st author	3	35	-	-
Noon Conf or Fac Dev-Repeated	5	5	-	-	Abstract Publ. 1st author-Revised	1.5	17.5	-	-
Predoc or Residency Lecture-New	4	15	-	-	Abstract Publ. Other author	2	20	-	-
Predoc or Residency Lecture-Repeated	4	5	-	-	Abstract Publ. Other author-Revised	1	10	-	-
Inpatient Rounds Topic-New	4	5	-	-	FPIN Clin Inquiry First Author	5	20	-	-
Inpatient Rounds Topic-Repeated	4	2	-	-	FPIN Clin Inquiry Other Author	5	10	-	-
Community Education	2	5	-	-	Textbook Chapter	4.5	35	-	-
CME Presentation-New	2	15	-	-	Manuscript Submitted 1st	4	45	-	-
CME Presentation-Repeated	2	5	-	-	Manuscript Submitted 1st-Revised	2	22.5	-	-
Life Support teaching (per topic)	1	1	-	-	Manuscript Submitted Other	3	30	-	-
Life Support Course Director	1.5	10	-	-	Manuscript Submitted Other-Revised	1.5	15	-	-
Journal Club	3	5	-	-	Manuscript Publ. Non-Peer-1st	5	45	-	-
New Curriculum	5	20	-	-	M'script Publ. Non-Peer-1st-Revised	2.5	22.5	-	-
Blackboard Online Course	4	0	-	-	M'script Publ. Non-Peer Other	4	25	-	-
Prof. Conf.-Invited Address	5	20	-	-	M'script Publ. Non-Peer Other-Revised	2	12.5	-	-
CLINICAL TEACHING				M'script Publ. Peer 1st author					
1/2 Day Student in Clinic	2	4	-	-	M'script Publ. Peer 1st author-Revised	5	22.5	-	-
Home Visits	2	2	-	-	Manuscript Publ. Peer Other	5	40	-	-
Sports Med Event	2	3	-	-	Manuscript Publ. Peer Other-Revised	2.5	10	-	-
Behav Sci Seminar	2.5	2	-	-	GRANTS WRITTEN				
Res. Research Supervision	2	10	-	-	Institutional submitted	3	20	-	-
Nursing Home teaching Rds	2	3	-	-	Institutional funded	3	20	-	-
Resident or Student Advising	2	1	-	-	Local/Regional submitted	4	20	-	-
Other	1	1	-	-	Local/Regional funded	4	20	-	-
ADMINISTRATION				Federal Training submitted					
Committee Chair	3	1	-	-	Federal Training funded	4	40	-	-
Committee Member	1	1	-	-	Foundation submitted	5	30	-	-
Grant administration	4	1	-	-	Foundation funded	5	30	-	-
Special Admin. Assignment	0	1	-	-	Federal Research submitted	6	70	-	-
OTHER				Federal Research funded					
Community Advisory Board	1	12	-	-	Federal Research funded	6	70	-	-
Officer-Prof.Organization	2	12	-	-	OTHER				
Award/Hon(Prof.,teach,etc)					Editorial Board	3	25	-	-
Department	5	20			Peer Reviewer-per m'script	3	5	-	-
School	10	20			IRB protocol approved	2	20	-	-
Regional	15	20			USAFP CME presentation	2	20	-	-
National	15	20			USAFP CME workshop	2	30	-	-
Community Service	5	20			Poster Presentation	3	20	-	-
Other Prof/Comm. activity related to Mission/Scholarly goals	1	1			Poster co-author	3	10	-	-
TOTAL				Prof. Conf. Research Presentation					
					Prof. Conf. Research Co-author	4	40	-	-
					CQI project presented-1st author	4	30	-	-
					CQI project presented-coauthor	4	15	-	-
					Humanitarian trip (1-3 weeks)	1	50	-	-
					Community Activ. (Church, coach, PTA, etc.)	1	1	-	-
					TOTAL				
Due Dates: Quarterly				GRAND TOTAL					

INTERN ORIENTATION

1. The Family Medicine Program Coordinator coordinates the incoming intern orientation program. He/she will plan the agenda, in cooperation with other staff, the residency director, coordinator, residents and their spouses.

2. Necessary areas to schedule:

- DEERS/ID/CAC card
- Base In-processing List
- Hospital routine In-processing List/Hosp ID badge
- CBPO/Finance
- Orderly Room (CSS)/Officer Records
- Immunizations/Dental Evaluations
- Official Photo
- Ward Orientation/Shadow teams
- Readiness/Disaster
- CHCS/AHLTA (Info Systems)
- Hospital newcomers brief
- Pharmacy
- Training at VA, UMC and Sunrise

Initial Training

- BLS
- ACLS
- ALSO
- NRP
- PALS

3. Additional important aspects to cover:

- Program Director/Staff Introductions
- Professionalism/Courtesies
- Welcoming Picnic
- Intern/Resident Real Truth Party
- Scholarly Activity graduation requirements/ Medical Library and AF Virtual Library

CURRICULUM VITAE

(All staff members should complete and update a curriculum vitae to be kept on file by the program coordinator and USUHS administrative staff. In return for teaching a core USUHS MS3 rotation, you SHOULD apply for title of Assist Professor of Family Medicine. The CV template for USU is shown below): <http://www.usuhs.mil/medschool/deans/associatedeans/faculty/cvbuilder.html>

I. PERSONAL DATA

Name:
Address:
E-Mail/Tel#:
Citizenship:

II. EDUCATION

<u>Year</u>	<u>Degree</u>	<u>Institution</u>
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III. POST GRADUATE EDUCATION

<u>Year</u>	<u>Position</u>	<u>Institution</u>
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IV. ACADEMIC APPOINTMENTS

<u>Year</u>	<u>Position</u>	<u>Institution</u>
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V. OTHER EMPLOYMENT PERTAINING TO CURRENT PROFESSIONAL APPT

VI. MILITARY SERVICE

<u>Previous Assignments</u>	<u>Duty Title</u>
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VII. CERTIFICATION AND LICENSURE

<u>Date</u>	<u>Number</u>
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Certification Board(s)

License(s)

VIII. MEMBERSHIP IN SCIENTIFIC SOCIETIES/PROFESSIONAL ORGANIZATIONS

(Offices held, if applicable)

IX. AREAS OF RESEARCH INTEREST

X. CURRENT PROTOCOLS

<u>Title</u>	<u>Funded (amount)</u>	<u>Grant Period</u>
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XI. **TEACHING ACTIVITIES FOR THE PAST FIVE YEARS** (Specifically state involvement with "USUHS students" to qualify for teaching assignment).

XII. **OTHER PROFESSIONAL ACTIVITIES**
(no more than five)

XIII. **CLINICAL ACTIVITIES**
(Attending, consultant; days/week and months/year)

XIV. **COMMITTEES** (national advisory, professional societies, hospitals)
(list the five most significant)

XV. **HONORS AND AWARDS**
(for military include military awards)

XVI. **BIBLIOGRAPHY**

FAMILY MEDICINE FACULTY DEVELOPMENT OPPORTUNITIES

University of North Carolina at Chapel Hill

School of Medicine
University of North Carolina at Chapel Hill
Department of Family Medicine / Faculty Development Fellowship
Manning Dr, Campus Box 7595
Chapel Hill, NC 27599-7595
Phone: (919) 966-3562
(919) 966-6125

Society of Teachers in Family Medicine

8880 Ward Parkway
PO Box 8729
Kansas City, MO 64114
Phone: (816) 333-9700
(800) 274-2237
Web site: <http://www.stfm.org>

USAFP Scientific Assembly Annual FD Workshops