

University of Alabama

Tuscaloosa Family Medicine Residency Handbook

Academic Year 2026-2027

Approved by the Graduate Medical Education Committee on
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Note: This handbook is subject to revision. The reader is advised to only reference the version of the handbook as is posted online.

In the event of a conflict between this handbook and UA or CCHS policy, the policy will prevail.



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Sponsoring Institution Information

Introduction

Within this handbook, you will find resources on the College of Community Health Sciences, as well as relevant policies and procedures, available resources, and many other topics.

The policies and procedures listed herein are subject to change as they are yearly reviewed, so trainees are advised to always use the web links provided when referring to policy and procedure.

This handbook is divided into two sections:

- The beginning of the handbook is applicable to trainees in all programs, from our Psychiatry Residency and Family Medicine Residency to our seven different post-residency fellowships. It contains general information about the College and its role as the Sponsoring Institution for the University's Graduate Medical Education programs. You will find links to valuable resources and important policies.
- The second part of this handbook contains information specific to your program.

The absence of policy, procedure and any other regulations and guidelines from this Handbook does not excuse the trainee from their responsibility to be aware of such as they may apply to trainees.

This Handbook should not be construed as, and does not constitute, an offer of employment by the University for any specific duration, nor is it intended to state any terms of employment not otherwise adopted and incorporated as part of any Trainee Agreement.

About the College

The College of Community Health Sciences

The College of Community Health Sciences was established at The University of Alabama in 1972 in response to the Alabama Legislature's mandate to solve the critical need for health care in rural Alabama. That same year, the College was also designated as a regional campus of the UAB Heersink School of Medicine to provide clinical training to medical students. Dr. William R. Willard was recruited as the College's first dean following his retirement from the University of Kentucky. Willard, known as the father of family medicine for his national role in establishing family medicine as a specialty, began recruiting faculty and staff, and the College's first full-time students enrolled in 1974.

Since that time, the College has educated more than 500 family medicine physicians who are working in medical practices, hospitals and universities throughout the United States. In its role as the Tuscaloosa Regional Campus of the Heersink School of Medicine, formerly the UAB School of Medicine, the College has educated more than 900 medical students who have been competitive in obtaining entry to prestigious residencies across the country in family medicine and other specialties, including internal medicine, pediatrics, obstetrics and gynecology, psychiatry, neurology and surgery.

The College's first medical clinic opened in 1975 in Tuscaloosa and by 1993 had 13,800 patients. Today, University Medical Center provides comprehensive patient-centered care from six locations – University Medical Center, located on the UA campus, UMC-Northport, UMC-Demopolis, UMC-Livingston, UMC-Fayette and UMC-Carrollton – that forms the largest community practice in West Alabama with more than 150,000 annual patient visits. University Medical Center also serves as the base for the College's clinical teaching program. In addition, the College also operates the UA Student Health Center and Pharmacy.

CCHS faculty and graduate students engage in research and scholarship and provide community outreach through the Institute for Rural Health Research, established by the College in 2001 with the goal of improving health in Alabama and the region.

In April 2025, the College received Initial Accreditation from the ACGME for a Psychiatry Residency program. The new residency will bolster the great work of the College and the Family Medicine Residency in improving and promoting the health of individuals and communities in rural Alabama and the Southeast region.

Capstone Health Services Foundation

The Capstone Health Services Foundation (CHSF) is a separate 501(c)-3 organization serving as the physician's practice plan. CHSF is an affiliated foundation of The University of Alabama. CHSF operates the University Medical Center (UMC) and its several locations, as well as the Capstone Hospitalist Group.

Mission

We are dedicated to improving and promoting the health of individuals and communities in Alabama and the Southeast region through leadership in medical and health-related education, primary care and population health; the provision of high quality, accessible health care services; and research and scholarship.

We pursue this mission by:

- Shaping globally capable, locally relevant and culturally competent physicians through learner-centered, innovative, community-based programs across the continuum of medical education.
- Forging a reputation as a leading health sciences academic research center.
- Providing high-quality, patient-centered and accessible clinical services delivered by health-care professionals of all disciplines.
- Creating a culture of employee wellness and growth.

Graduate Medical Education at The University of Alabama

The College of Community Health Sciences (CCHS) is the sponsoring institution for all Accreditation Council for Graduate Medical Education (ACGME) graduate medical education (GME) programs offered at The University of Alabama. The ACGME requires that graduate medical education programs operate under the authority and control of one sponsoring institution. In addition, there must be an organized administrative system led by a Designated Institutional Official (DIO) in collaboration with a Graduate Medical Education Committee (GMEC) that oversees all ACGME-accredited programs of the sponsoring institution. CCHS's GMEC has been charged to oversee all GME programs regardless of accreditation status. It is not uncommon for sponsoring institutions to have advanced training programs (Fellowships) in areas in which specialty board accreditation or certification is not offered. At CCHS, all GME programs are held to the same standards of compliance and monitoring as established by ACGME. Table One depicts CCHS's graduate medical education programs.

The Sponsoring Institution is home to a Residency in Psychiatry and Family Medicine, as well as seven fellowships. Of these programs, the Residencies and the Sports and Geriatric Medicine fellowships are all ACGME accredited. See **Table One** for program overview.

Table One – GME Programs at CCHS

PROGRAM NAME	ACCREDITATION AGENCY	PROGRAM DIRECTOR	NUMBER OF APPROVED TRAINEES	TRAINING PERIOD (YRS)
Psychiatry Residency	ACGME	James Reeves, MD	24	4
Family Medicine Residency	ACGME	Tamer Elsayed, MD	48	3
Sports Medicine Fellowship	ACGME	Ray Stewart, MD	3	1
Geriatric Fellowship	ACGME	Anne Halli-Tierney, MD	2	1
FM-OB Fellowship	None	Cathy Lavender, MD	4	1
FM Hospitalist Fellowship	None	Charles Brant Lehman, MD	6	1
FM Behavioral Medicine Fellowship	None	Marissa Giggie, MD	2	1
FM Emergency Medicine	None	Tamer Elsayed, MD	2	1
FM Pediatrics Fellowship	None	Sara Phillips, MD	1	1

The DIO for the sponsoring institution is Dan Walters, JD, MBA. Mr. Walters was appointed DIO in December 2020. The DIO has the authority and responsibility for oversight and administration for all the GME programs at CCHS (regardless of ACGME accreditation) and works in collaboration with the GMEC for its oversight of all graduate medical education programs and activities.

The GMEC is comprised of program directors from the residency and fellowship programs, a designated representative from DCH Regional Medical Center, the participating site in which our trainees do most of their inpatient training, as well as program faculty, peer-selected residents and fellows and a quality improvement/patient safety officer.

The ACGME tasks the GMEC with oversight ¹ of:

- ACGME accreditation and recognition statuses of the Sponsoring Institution and each of its ACGME-accredited programs.
- the quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites.
- the quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty-/subspecialty-specific Program Requirements.
- the ACGME-accredited program(s)' annual program evaluation(s) and Self-Study(s).
- ACGME-accredited programs' implementation of institutional policy(ices) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence, at least annually.
- all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution; and,
- the provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided.

Additionally, GMEC is responsible for the review and approval ² of:

- institutional GME policies and procedures.
- GMEC subcommittee actions that address required GMEC responsibilities.
- annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits.
- applications for ACGME accreditation of new programs.
- requests for permanent changes in resident/fellow complement.
- major changes in each of its ACGME-accredited programs' structure or duration of education, including any change in the designation of a program's primary clinical site.
- additions and deletions of each of its ACGME-accredited programs' participating sites.
- appointment of new program directors.
- progress reports requested by a Review Committee.
- requests for exceptions to clinical and educational work hour requirements.
- voluntary withdrawal of ACGME program accreditation or recognition.
- requests for appeal of an adverse action by a Review Committee; and,
- appeal presentations to an ACGME Appeals Panel; and,
- exceptionally qualified candidates for resident/fellow appointments who do not satisfy the Sponsoring Institution's resident/fellow eligibility policy and/or resident/fellow eligibility requirements in the Common Program Requirements.

¹ ACGME Institutional Requirements 2025, 1.12.

² ACGME Institutional Requirements 2025, 1.13.

Policies and Procedures

The Sponsoring Institution maintains policies specific to its GME endeavor. Additionally, trainees should reference [CCHS policies](#), many of which will be applicable to trainees. Finally, trainees are encouraged to review [University of Alabama policies](#), paying special attention to those regarding employment. Trainees should also consult the [UA Employee Handbook and Policy Manual](#).

Policies are reviewed and updated on a regular basis; therefore, trainees should refer to these online postings of policy, rather than any paper versions to ensure they are accessing the most recent version. Further, from time-to-time policies may be created or retired. These changes will be reflected on the [Sponsoring Institution Policy page](#).

[Sponsoring Institution Policies](#) include:

1. Eligibility, Recruitment, and Appointment
2. Promotion, Appointment Renewal and Dismissal
3. Due Process
4. Grievances
5. Leave
6. Impairment
7. Harassment
8. Accommodation for Disabilities
9. Supervision and Accountability
10. Clinical and Education Work Hours
11. Moonlighting
12. Vendors
13. Non-competition
14. Disaster and Substantial Disruption
15. Program Closures and Reductions
16. Probation-Remediation-Suspension
17. Professional Appearance Policy
18. Well-Being, Fatigue Mitigation and Monitoring
19. Professionalism
20. Non-Discrimination

Expectations for Professionalism and Reporting Avenues

Professionalism is vital to the clinical practice of medicine and to trainee development. To that end, trainees will be evaluated on professionalism through the milestone process. Professionalism concerns will be addressed immediately. Further, professionalism is fundamental to the College's Mission and to all its critical endeavors; clinical, educational, research, and otherwise. As such, the Institution expects the utmost professionalism from its trainees and all other participants associated with graduate medical education.

This expectation of professionalism extends to a trainee's peers, faculty, staff, students, other providers, patients, and all other individuals with whom the trainee interacts during their training. Trainees are advised that concerns regarding their professionalism will be reported to the Dean.

If trainees feel that they have experienced unprofessional behavior during their training from any party, they are encouraged to report to their Program Leadership, the DIO, the CCHS Associate Dean of Academic Affairs, or the CCHS Dean. Programs may have other means of reporting available. Every effort will be made to remedy any professionalism issues within the training environment. Trainees may also refer to the [College's professionalism reporting channels](#).

Trainees may find further information regarding allegations of sexual misconduct at the [University's Title IX Page](#).

Dr. Sara Phillips, MD, is the College's Designated Harassment Resource Person, and is specially trained and designated to receive complaints of harassment. Dr. Phillips is available at (205) 348-1220 or sbphillips@ua.edu.

Trainees are encouraged to reference the following policies:

- Sponsoring Institution [Grievance](#) Policy
- Sponsoring Institution [Harassment](#) Policy
- The University of Alabama's [Equal Opportunity Policies](#)
- University of Alabama's [Title IX & Sexual Misconduct Policy](#)
- The Sponsoring Institution's [Professionalism](#) Policy

Working with Medical Students

The College of Community Health Sciences serves as an academic and clinical home for the Tuscaloosa Regional Campus of the University of Alabama Heersink School of Medicine. Third- and fourth-year medical students are assigned to the various specialty services at University Medical Center. While the ultimate responsibility for students' education remains with the faculty, trainees are expected to be involved in the teaching of medical students.

Trainees are reminded of their obligation of professionalism in their work with Medical Students. The College has zero tolerance for unprofessional behavior.

Trainees are to allow and expect medical students to perform histories and physicals, formulate ideas concerning impressions and diagnoses, and suggest treatments. Trainees are to see the patients either with or following the students to make sure findings and assessments are accurate and to provide opportunities for necessary instruction. Trainees are expected to assist students with these presentations whenever time permits. Students will be allowed to perform procedures under direct supervision of fellows or faculty. Orders are to be countersigned immediately in all instances by the trainee responsible for the patient.

Trainees should familiarize themselves with the clerkship procedures for each medical student clerkship for which the trainees are assigned. Clerkship goals, procedures, and objectives will be sent to the trainee prior to the clerkship. Trainees will also attend a lecture/seminar on providing appropriate feedback and teaching skills aimed at medical students.

The trainees may require the student to do reasonable reading and research on a patient. The student should be familiar with all pertinent laboratory and clinical facts. Ideally, the student should present the patient to the Attending for comments and guidance, with the help of the trainee on rounds. Interns must perform and dictate a separate H&P from that of the medical student.

At University Medical Center Clinics or participating sites, a fellow **or** an attending, or an upper-level resident **and** an attending, must review all patients seen by a medical student. The Attending or Fellow should personally see the patient prior to the conclusion of the patient visit.

Evaluations of students' performance will be requested from trainees for each student under his/her instruction. These are to be filled out online and returned to the clerkship directors in accordance with UME reporting timelines.

Wellbeing

Mental Health

CCHS provides Residents and Fellows access to no-fee, confidential counseling services for individual and/or relationship counseling. The only information that the counselor shares with us is the number of individuals served per month to determine whether or not to continue offering the service.

Who: Mona Ochoa-Horshok, LPC

What: Confidential Counseling

Cost: Free to Residents, Fellows, and UASOM-Tuscaloosa Medical Students

When: Two evenings a month, between 5:30 and 7:30 pm; and as needed

Where: UMC - Please contact Mona for an appointment.

Appointments: mochoahorshok@gmail.com or Call/Text (205) 393-9029

Who: Harriet Myers PhD

What: Confidential Counseling

Cost: Free to Residents, Fellows,

When: Tuesday evenings, between 5:30 and 7:30 pm; alternate times or prn appointments are also available and can be scheduled as needed.

Where: UMC - Please contact Dr. Myers for an appointment and location.

Appointments: harrietmyers@gmail.com text (205) 394-8801

Physicians have a higher frequency of drug abuse, burnout, affective disorders, and marital disharmony than other people of similar social standing. Suicide is more frequent among physicians, possibly because doctors are reluctant to acknowledge illness or difficulties. The faculty of CCHS recognizes the potential for emotional difficulties among trainees and the need for assistance. Physicians in training who are having difficulty may bring this to the attention of the Residency Director or their Advisor without fear of consequence or disapproval. Confidentiality is important. Trainees are encouraged to consult with psychiatry and behavioral medicine providers as needed.

The College also provides trainees with a wellness tracker tool, the Wellbeing Index, at no charge. Interested trainees should consult Dr. James Reeves (jjreeves@ua.edu) for further detail.

If there is interest in obtaining assistance outside the College, several professional resources are available. A brief directory of community resources includes:

[The University of Alabama Employee Assistance Program \(EAP\)](#)

Your [ComPsych GuidanceResources](#) program can help! The EAP is designed to provide eligible employees and their family members with resources for resolving work-related and personal problems. Personal setbacks, emotional conflicts or just the demands of daily life can affect your work, health and family. With help from your [GuidanceResources®](#) program, they don't have to. This UA-sponsored benefit is available to you and your family members at no cost and gives you someone to talk to when life's challenges threaten to overwhelm you. The program is staffed by highly trained, caring clinicians

who are available by phone or online 24 hours a day, seven days a week.

Call **1-888-283-3515** any time with personal concerns, including:

- Stress, anxiety and depression
- Marital and family conflicts
- Alcohol or drug use
- Job-related pressures
- Dealing with change
- Grief and loss

The Employee Assistance Program provides a free assessment, short-term counseling (5 sessions per issue per year), and long-term referral services. Referrals are made in consultation with you if additional mental health services are needed. The [behavioral health benefits](#) provided by Blue Cross and Blue Shield of Alabama will be explored with you in selecting a provider.

EAP services are always confidential. Information regarding you and your counseling sessions is not released to your manager or supervisor and will not be made a part of your personnel file. [Watch a video](#) where ComPsych answers some questions about counseling. Only statistical data is reported to the University that provides a composite of the employee population served. Your right to privacy is protected within the State of Alabama and federal guidelines.

Other Resources:

[Alabama Professionals Health Program](#): (334) 954-2596

Administrative Practices

1. Trainee Agreement

The Trainee Agreement is issued prior to beginning initial training, and only after Trainees have received acceptable results on their pre-employment drug & alcohol screen as well as satisfactorily completing any other pre-employment requirements as may be required by the Program, College, or University.

2. Human Resources

The University's Human Resources is available for further information on matters of employment with the University. Trainees can contact the HR Service Center at 205-348-7732 or hrrsvctr@ua.edu. Trainees may visit UA HR's [Employee Resources page](#) for helpful references. Finally, Trainees should review the [UA Employee Handbook & Policy Manual](#). A selection of the important items in the UA Employee Handbook are listed below, however trainees should review the entire document:

- Equal Opportunity, Non-Discrimination, and Affirmative Action/Affirmative Action Program
- Anti-Retaliation
- Voluntary Reporting of Protected Veteran and/or Disability Status
- University Drug-Free Campus and Workplace and Other Alcohol Policies
- Title IX and Sexual Misconduct Policy Compliance
- FMLA/Parental Leave

3. Compliance

- HIPAA, Infection Control, and Confidentiality Agreement: CCHS requires mandatory training at the beginning of employment and annual renewal thereafter. Certification is documented via the trainee signing and submitting an acknowledgement form. These training courses and the acknowledgement form can be found on the CCHS Intranet site.
- UA Compliance Training: To meet state and federal requirements as well as University of Alabama policy, University faculty, staff, and students may be required to take mandatory training on specific topics. Many of the mandatory compliance training courses must have the course or a refresher course completed on an annual basis. Refer to the [Compliance, Ethics, & Regulatory Affairs website](#) for an overview on [Compliance Training](#).
- Sexually Explicit Material: Pornographic material of any kind (videos, screen savers, posters, etc.) is prohibited in any portion of CCHS or other sites in which trainees are assigned.
- Working with Minors: Trainees should be aware of the [University's Child Abuse Reporting Policy & Procedures](#), as well as the [College's Sensitive Physical Examination](#)

Policy. Trainee's patient panels will include patients of all ages, including minor children. In addition, there is a possibility that trainees will work with shadow students. To protect trainees and minor children, all University training courses regarding child protection must be completed as required in a timely manner.

- Other Compliance courses may be deemed mandatory and required to be completed by trainees as determined by CCHS and/or The University of Alabama. Timely completion is expected.

4. Salary and Paychecks

- The University of Alabama pays Residents a graduated salary, and Fellows the stated salary, subject to such withholdings as required by law or authorized by the trainee. The salary is specified in the trainee's Agreement. Trainees are paid in 12 equal monthly installments, by direct deposit, on the last day of each month. Any questions concerning monthly paychecks should be directed to The University of Alabama Payroll Office at (205) 348-7732. While paid a salary, trainees are considered neither faculty nor staff of CCHS or The University of Alabama but rather are generally classified by the University as post-doctoral graduate students with regard to athletic, social, and cultural events, use of University facilities, participation in University governance, parking privileges, and University services. *(Note for PGY-1 Residents: Interns (PGY-1) begin required training on a program-specific start date prior to July 1. The PGY-1 salary includes this required pre-residency training and orientation period, as well as twelve (12) months of residency training, and is paid in thirteen (13) equal installments over the training year. Interns are to collect their first paycheck by direct deposit. However, if residents do not set-up direct deposit during the onboarding process, the first check will be a paper check that would have to be picked up at the HR Service Center.)*
- Salaries are not intended as compensation for services rendered by the trainee. Although it is believed that an essential part of training includes assigned responsibilities for patient care, under the supervision of faculty physicians and consistent with their skills and experience, receipt of the agreed upon salary shall in no way be conditioned upon, measured by, or related to any patient care service rendered by the trainee incidental to the training program.
- Trainees should be aware that receiving direct patient care compensation is considered "moonlighting," which is subject not only to the rules of the program and the ACGME, but also to various federal laws stipulated by the Centers for Medicare and Medicaid Services (CMS). Trainees should refer to their program's Moonlighting policy for further guidance.

5. Malpractice Coverage

- For training duties, the University provides an occurrence-based malpractice policy through The University of Alabama at Birmingham Professional Liability Trust Fund. This policy covers the trainee during official duties. Moonlighting activities may not be covered under this policy. Trainees should refer to their program's Moonlighting Policy to understand the insurance ramifications of moonlighting.

6. Leave

- To take leave, a trainee must have properly prepared leave request with the approval signature of the Program Director or his/her designee.
- Trainees should refer to the [sponsoring institution's leave policy](#) as well as those guidelines set forth by their program.
- Family and Medical Leave Act: In accordance with the Family and Medical Leave (FMLA) Act of 1993, eligible trainees may take FMLA as described in the FMLA policy. Trainees should be aware that protracted FMLA absences may affect time toward board eligibility and may postpone graduation date. Trainees should reference [UA HR's FMLA page](#).
- Administrative Leave: Trainees may be granted administrative leave for activities whereby they directly represent CCHS and their program (e.g., national and regional residency meetings, presentation of papers, residency fairs, etc.). Applications for administrative leave will be submitted and processed in the same manner as all leave requests.
- Holidays: The holidays typically provided by The University of Alabama include New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Juneteenth, Labor Day, Thanksgiving Day, the Friday after Thanksgiving, Christmas Eve Day, Christmas Day, New Year's Eve Day, New Year's Day. University Medical Center is closed on these days, and hospital services operate on weekend schedules. Trainees should not make vacation/holiday plans until their program establishes its holiday training schedule.

7. Risk Management, Potential Litigation, and Safety Learning Reports

If a trainee receives communication from a lawyer, patient, or insurance company about possible litigation, the trainee should immediately inform the Program Director and DIO, **in person or telephone, and telephone** the Clinical Risk Director (Amber Starr, 205-903-4229). Ms. Starr will instruct the trainees on who to notify and who to restrict communications with regarding a possible litigious situation to oral communications. **DO NOT address the specifics of any potential malpractice case in writing, email, text or social media content.** Also inform the Program Director of the conversation with Ms. Starr. As appropriate, the Program Director may ask the trainee to update the Chief of the service directly related to the potential case, but here again, do so via oral communication only. Ms. Starr will be responsible for obtaining any documents she needs to review, as this allows her to protect certain confidential information and assists her in the discovery process. Trainees are not to gather any information for her unless specifically requested by her. No trainee should give any information personally or over the phone to an insurance carrier or lawyer other than our own without permission from Ms. Starr.

Early recognition and full reporting of potential claims will often lead to clarification and resolution of patient dissatisfaction and prevention of litigation. When this process reveals a legitimate error, early resolution of the issue often prevents long, drawn out, costly, and emotionally wearing litigation.

Sensitivity to dissatisfaction on the part of the patient, his or her family, or “significant others” is an essential skill for successful practice. Clear communication with patients and families, coupled with that sensitivity, is the best protection against professional liability claims.

Safety Learning (incident) Reporting is an opportunity for a resident to document instances where patients or families even hint that they are dissatisfied or that they are considering seeking legal advice. Submission of such reports will not be construed as evidence of poor performance on the part of the trainee, but rather that the trainee is sensitive and aware of patient and family attitudes that are not favorable to the doctor-patient relationship.

8. Immunizations

- Hepatitis Immunization – Since trainees are among the high-risk group for hepatitis B, they will be screened for susceptibility if they have not been screened previously. All individuals found to be susceptible will be notified and required to obtain hepatitis immunization. Capstone Health Services Foundation will pay for immunization.
- TB Testing – Trainees will receive a free PPD test during orientation and thereafter as needed for rotations.
- Varicella Testing – All trainees who have not had chickenpox will receive two doses of varicella vaccine (VARIVAX).
- MMR – All trainees are required to have two doses of measles/mumps/rubella (MMR) vaccine since their first birthday. Trainees who are unsure of their immunization will receive MMR.
- N95 Mask Fitting – All trainees may be required to be fitted for an N95 mask annually.
- Flu Shot – Trainees will receive free yearly flu shots. Those who choose not to have a flu shot will be required to wear a mask in the clinic areas throughout flu season in keeping with University Medical Center policy.

9. Accommodation for Disabilities

Trainees should reference the [University's ADA page](#) for more information on reasonable accommodations to qualified individuals with disabilities and/or disabled veterans.

10. Workplace Relationships

The University of Alabama has a [Consensual Romantic Relationships Policy](#) that applies to trainees.

The Policy states, in part: “Employees shall not engage in consensual romantic or sexual relationships with any student or employee over whom they exercise any academic, administrative, supervisory, evaluative, counseling, advisory, or extracurricular authority or influence. This prohibition includes employees engaging in consensual romantic or sexual relationships with other employees when one party to the relationship is an individual who supervises, evaluates, makes assignments for, or grades the other party (i.e. “supervisor/subordinate relationship”). Likewise, employees who have the authority to influence aid, benefits, or services provided to a student may not engage in consensual romantic or sexual relationships with a student seeking such aid, benefits, or services. Similarly, employees who have the authority to influence the academic progress of a student may not engage in consensual romantic or sexual relationships with that student.”

Trainees are encouraged to view the policy online to review full content and access the latest version.

11. Benefits

A. The College of Community Health Sciences (CCHS) and the Capstone Health Services Foundation (CHSF) will provide trainees with the following:

- Alabama Controlled Substance fees
- Alabama Medical Licensure Commission fees
- Alabama State Board of Medical Examiner fees
- DCH Regional Medical Center Medical Staff privileges
- Educational Reimbursement (CME funds)- See program details
- Federal Drug Enforcement Agency (DEA) license
- Lab Coats (2)
- Occurrence Malpractice Insurance
- Parking permit codes to DCH parking lot
- Portable disability insurance (with buy-up plans available at extra cost to the trainee)
- University of Alabama Business Cards
- University of Alabama Parking Pass
- University of Alabama Staff ACT card

Individual programs may have additional benefits; see program information.

If a trainee receives a bill or statement from any of the above, they should promptly submit it to their program coordinator for payment.

- B. The University of Alabama offers an array of benefits for the trainees, about which details may be found on the [UA Benefits website](#). UA has also provided a [Benefits Summary Guide](#).

Some employee benefits require timely action by trainees, to include health insurance and retirement plan options. Trainees are responsible for completing the online benefit enrollment process within the first **30** days of employment. Failure to do so will result in ineligibility status until the official open enrollment period begins.

12. Equal Opportunity and Non-Discrimination

The University of Alabama (UA) is committed to compliance with all applicable laws regarding the concept and practice of equal opportunity, non-discrimination (including anti-retaliation and reasonable accommodation) and affirmative action in all aspects of employment practice.

Trainees should review the [University's Equal Opportunity and Non-Discrimination Policy](#).

Severe Weather Guidelines

One of the methods The University of Alabama uses for emergency notification is UA Alerts. In an emergency, University Relations will activate the system, sending telephone calls (work, cell, and/or home), e-mail, and text (SMS) messages simultaneously to the campus community.

[Find more information about UA Alerts.](#)

[Users will be able to update their personal information using their myBama portal.](#)

If a trainee feels unsafe to travel due to weather, they should contact and discuss with their supervisor and/or program leadership prior to travel.

Trainees should be aware that tornadoes can be a threat in Alabama. The UA Alerts system will notify trainees of threatening weather for the UA Campus. Tornado shelters are located at several locations across campus. Tornado watches refer to weather conditions which are favorable for tornado formation. Tornado warning refers to a confirmed tornado in the area.

Programs may have program specific severe weather practices. Trainees should reference the program section of this handbook.

Program Information

The remainder of the handbook contains information specific to your program.

This information is reviewed and updated by Program Directors each year. Any questions on this information should be directed to Program Leadership.

University of Alabama Tuscaloosa Family Medicine Residency

Program Information

I. History of the University of Alabama – Tuscaloosa Family Medicine Residency Program

Origins and Founding Mission

In the late 1960s, the United States faced a severe shortage of physicians, particularly in rural and underserved communities. As a response, the **College of Community Health Sciences (CCHS)** was founded in 1972 at **the University of Alabama**, with a mandate from the Alabama State Legislature to expand healthcare access throughout the state.

At that time, many physicians were entering specialized fields and urban practices, leaving Alabama's rural communities underserved. CCHS responded by emphasizing **family medicine** as a solution, training doctors who can handle a wide range of medical issues in various settings.

Program Establishment and Growth

The **Tuscaloosa Family Medicine Residency Program (UATFMR)** was launched in **1974** as a core initiative of the College. The first class graduated in **1977**. Since then, the program has grown significantly in size and impact:

- **2012:** Annual residency intake increased from 12 to 15 residents.
- **2015:** Transitioned to a 16-16-16 model, reaching a total of **48 residents** by July 2017.

This expansion was designed to address the growing healthcare needs in Alabama's rural regions. Today, **one in seven family medicine physicians in Alabama** is a graduate of UATFMR.

Curriculum and Clinical Training

UATFMR is an **unopposed, university-based residency program** that emphasizes:

1. **Comprehensive, community-based training and service**
2. **Preparation for board certification in Family Medicine**

3. **Training at DCH Regional Medical Center**, a 620-bed referral hospital serving West Alabama and **Northport Medical Center**.

Residents are supported by:

- A robust team of **full-time faculty**
- Dedicated **community physician volunteers**

UATFMR residents consistently perform in the **top 20% nationally** on Family Medicine board exams.

Fellowship Opportunities

To promote advanced training and meet emerging community health needs, UATFMR offers several fellowship programs:

- **Sports Medicine**
- **Geriatric Medicine**
- **Obstetrics**
- **Emergency Medicine**
- **Pediatrics**
- **Behavioral Medicine**
- **Hospital Medicine**

These fellowships equip family physicians with specialized skills that enhance care delivery across diverse populations.

Impact and Legacy

Since its inception, UATFMR has graduated over **600 physicians**, now practicing in more than **30 states and Canada**, including:

- **Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Tennessee, North Carolina, South Carolina, Oklahoma, Texas, and Virginia**

Key outcomes include:

- **Over 50% of graduates remain in Alabama**
- **The majority practice in rural or underserved areas, including Health Professional Shortage Areas (HPSAs)**

This impact reflects the enduring mission of the program: to train skilled, comprehensive, compassionate, community-oriented family physicians who serve where they are most needed.

II. College of Community Health Sciences (CCHS) and University Medical Center (UMC)

The **College of Community Health Sciences (CCHS)** oversees a network of multi-specialty clinical sites known as the **University Medical Center (UMC)** system. These clinics serve as vital health care access points across West Alabama and are integral to the clinical training of medical students and family medicine residents.

UMC Clinical Sites Operated by CCHS:

- **UMC – Main (Tuscaloosa campus)**
Located on the University of Alabama campus, UMC–Main is the flagship clinic and a large multi-specialty practice serving the wider West Alabama region. It functions as a teaching facility for various health professions and is the primary training site for our family medicine residents and medical students.
- **UMC – Northport**
- **UMC – Demopolis**
- **UMC – Carrollton**
- **UMC – Fayette**
- **UMC – Livingston**

Clinical Training Designation:

- **UMC – Main and UMC – Northport** are designated **ACGME-accredited continuity clinics**, providing core longitudinal experiences for residents in alignment with board eligibility requirements.

Oversight and Standardization:

All UMC clinics operate under a unified set of policies and procedures, governed by CCHS administrative leadership. This ensures consistent standards of care, education, and operational excellence across all sites.

III. Faculty

The College of Community Health Sciences is home to a diverse and interdisciplinary faculty of over **90 members**, who provide education, mentorship, research, and clinical supervision across a variety of departments.

CCHS Academic Departments:

1. **Community Medicine and Population Health**
2. **Family, Internal, and Rural Medicine**
3. **Obstetrics and Gynecology (OBGYN)**
4. **Pediatrics**
5. **Psychiatry and Behavioral Medicine**
6. **Surgery**
7. **Translational Science and Medicine**

These departments collaborate to support the College's mission of advancing health care in Alabama through education, research, and service. Faculty members play a central role in resident education, both in clinical and academic settings.

Program Aims & Goals

I. Program Aims

The University of Alabama – Tuscaloosa Family Medicine Residency Program is committed to promoting excellence in family medicine through the following aims:

1. Develop Globally Capable, Locally Relevant Physicians
2. Address Regional Workforce Needs

3. Partner with Communities in Urban and Rural Alabama
4. Deliver High-Quality, Patient-Centered Care
5. Lead in Health Equity and Outcomes Research
6. Promote Resident Well-Being and Professional Growth

II. Program Goals

- Prepare culturally competent, learner-centered physicians through innovative, community-based education across the full continuum of medical training.
- Serve as a standard of excellence in family medicine education to meet the primary care physician workforce needs of Alabama and the Southeastern United States.
- Engage rural and underserved communities as active partners in efforts to improve the health and well-being of Alabamians.
- Provide accessible, interdisciplinary clinical services that are compassionate, evidence-based, and centered on the patient's needs.
- Advance population health through community-oriented research and scholarship focused on eliminating health disparities and improving outcomes.
- Build and sustain an inclusive environment where all individuals—residents, faculty, staff, and patients—feel respected, supported, and empowered.
- Cultivate a culture that prioritizes resident wellness and professional fulfillment by offering resources, mentorship, and a supportive learning environment.

Lines of Authority, Administrative Structure, and Accreditation

I. Lines of Authority/Hierarchy

The University of Alabama – Tuscaloosa Family Medicine Residency Program (UATFMR) is led by a collaborative and multidisciplinary leadership team that oversees all aspects of resident education, supervision, wellness, and academic achievement.

Residency Leadership Team

- **Dr. Tamer Elsayed**
Residency Program Director
Chair Department of Family, Internal, and Rural Medicine
- **Dr. John E. Burkhardt**
Associate Residency Director – Behavioral Science Curriculum and Wellness
- **Dr. Louanne Friend**
Associate Residency Director – Research, Quality Improvement, and Professional Development
- **Dr. Anne D. Halli-Tierney**
Associate Residency Director – Clinical Competency and Evaluation
- **Dr. Russ Guin**
Associate Residency Director – Resident Recruitment and Patient Safety
- **Dr. Andrew Thomas**
Associate Residency Director – Curriculum and Didactics

Residency Administrative Support

- **Alison Adams** – Residency Program Coordinator
- **Genia Candra** – Residency Program Coordinator
- **Jeremy Cole** – Residency Program Coordinator Assistant

II. Administrative Structure

The **Residency Program Director** must possess full **responsibility, authority, and accountability** for all aspects of the residency program, including:

1. **Program administration and operations**
2. **Teaching and scholarly activity**
3. **Resident recruitment and selection**
4. **Resident evaluation, promotion, and disciplinary actions**
5. **Resident supervision**
6. **Educational oversight in the context of patient care**

This comprehensive role ensures the program remains compliant with accreditation standards and fosters an optimal learning environment for resident physicians.

Graduate Medical Education Committee (GMEC)

The GMEC provides institutional oversight for residency education. Voting members include:

1. Designated Institutional Official (DIO)
2. Residency and fellowship program directors
3. Peer-selected residents and fellows
4. Patient Safety/Quality Improvement Officer or designee
5. Representative from DCH Regional Medical Center (major participating site)

Residency Committees:

1. Program Evaluation Committee (PEC)

Chaired by the Program Director or their designee

Membership includes:

- Department chair of FIRM
- Program Director
- Associate Program Directors
- Senior Associate Dean for Academic Affairs
- Associate Dean of Curriculum and Evaluation
- Designated Institutional Officer
- GME institutional coordinator
- 2 resident representatives from each class
- OB department or FMOB representative
- Pediatric Department representatives
- Psychiatry Department representatives
- Residency Program Coordinator
- Others, as assigned by the Program Director
- Faculty representatives from each major discipline in the curriculum
- Resident representatives

The Program Evaluation Committee Responsibilities

- Participate in the planning, development, implementation, and evaluation of all educational activities.
- Review and recommend revisions to competency-based curriculum goals and objectives.
- Address areas of non-compliance with ACGME standards and review the program annually using evaluations of faculty, Fellows, and others;
- Prepare an **Annual Program Evaluation (APE)** to be presented to GMEC. This process will allow for a review of current educational activities and the determination of what changes are needed to ensure that competency-based curricular goals are met.

Reporting Channel: GMEC

Staff Support: Family Medicine Residency Coordinator

Meeting Times: Monthly

Minutes: Yes

2. Clinical Competency Committee

- The Clinical Competency Committee is a faculty committee appointed by the Program Director to review each resident's progress and advise the Program Director on each resident's development toward independent practice.
- The CCC does not replace the Program Director's authority; final decisions on evaluation and promotion rest with the Program Director, but its group review is the backbone of how your Milestones are determined.
- **Chair.** The committee is led by a CCC Chair, a senior core faculty member appointed by the Program Director. The Chair sets the agenda, assigns reviewers, ensures that a documented determination is made for every resident, and carries the committee's recommendations to the Program Director.
- **Members.** The CCC includes at least three program faculty members, including at least one core faculty member, and in practice seats a larger group to represent the breadth of program core faculty, Family Medicine Practice, behavioral health, and inpatient/OB faculty. Other health professionals with significant contact with residents may also serve.
- **CCD Duties** The committee reviews all resident evaluations at least semi-annually; synthesizes multi-source data (faculty and rotation evaluations, continuity-clinic metrics, in-training exam results, procedures and case logs, and peer, patient, and self-assessments); determines each resident's progress on the Family Medicine Milestones; and advises the Program Director ahead of your semi-annual review.
- For residents who are not progressing, the CCC's input informs an individualized learning or remediation plan, developed under the institution's Policies.

- **Meeting frequency.** The CCC meets at least twice a year and always before each resident's semiannual evaluation, typically on a fall-and-spring cycle aligned with ACGME Milestone reporting windows.
- **Administrative support.** The Program Coordinator supports the committee (non-voting) by assembling each resident's data packet in advance, scheduling meetings, recording minutes and determinations, maintaining the secure CCC record, and submitting Milestone determinations to the ACGME on schedule.
- **Reporting.** After each meeting, the Chair reports the committee's Milestone determinations and recommendations to the Program Director and Department chair, who (or whose designee) reviews your semi-annual evaluation and individualized learning plan **with the resident**.
- In aggregate and de-identified form, progression trends feed the Program Evaluation Committee and the Annual Program Evaluation, which are reported to the DIO and the **Graduate Medical Education Committee (GMEC)**. Milestone determinations are also submitted to the ACGME.

3. Residency Recruitment and Selection Committee

- The Recruitment & Selection Committee is a faculty and resident committee appointed by the Program Director to review, interview, and rank applicants to the program. Resident recruitment and selection are responsibilities of the Program Director, who retains final authority over applicant selection and the program's rank order list; the committee's structured, holistic review is how that work gets done.
- **Chair.** The committee is led by a Recruitment Chair, typically appointed by the Program Director, an Associate Program Director, or a senior core faculty member. The Chair sets the recruitment calendar and interview structure, assigns reviewers, standardizes scoring, leads deliberations on rankings, and forwards the committee's recommended rank list to the Program Director.
- **Members.** Membership represents the breadth of the program core faculty, Family Medicine Practice, behavioral health faculty, and current resident representatives, who interview applicants and advise on fit and rank. Other health professionals with significant program contact may also serve.
- **Committee duties.** The committee confirms applicant eligibility; conducts a holistic, mission- and community-aligned review and structured interviews; provides interviewed applicants with information about specialty board eligibility; and recommends a ranked list to the Program Director within the approved complement. All reviews comply with the institution's non-discrimination and employment policies, and no applicant or resident is required to sign a non-compete agreement.
- **Meeting frequency.** The committee meets for pre-season planning, regularly during interview season for a dedicated rank-order deliberation before the NRMP certification deadline, and for a post-Match debrief.
- **Administrative support.** The Program Coordinator supports the committee (non-voting): managing ERAS application flow, interview scheduling, and applicant communications;

maintaining secure recruitment records and the rank working file; and supporting NRMP registration, certification logistics, and onboarding of matched residents.

- **Reporting.** The Chair reports the recommended rank-ordered list and applicant evaluations to the Program Director and the Department Chair. The Program Director finalizes and certifies the list in NRMP. In aggregate, recruitment, selection, and retention data feed the Program Evaluation Committee and the Annual Program Evaluation, which are reported to the DIO and the **Graduate Medical Education Committee (GMEC)**. Eligibility, non-discrimination, and contracting compliance are coordinated with institutional GME and HR.

4. Curriculum and Didactics Committee

- The Curriculum & Didactic Committee is a faculty and resident committee appointed by the Program Director to design, maintain, and improve the educational program, the goals and objectives for each rotation, and the structured didactic curriculum. The Program Director retains final responsibility for the curriculum and learning environment; the committee's work is how that program is built and kept current.
- **Chair.** The committee is led by the Associate Residency Director for Curriculum and the Dedications. The Chair maintains the curriculum review calendar and the didactic schedule, assigns content and rotation leads, oversees mapping to the Competencies and Milestones, and presents curricular recommendations to the Program Director.
- **Members.** Membership represents the breadth of the curriculum content and rotation leads (inpatient, maternity/OB, pediatrics, geriatrics, MSK/sports, and more), a didactic/conference lead (often with chief residents), behavioral health faculty, Family Medicine Practice, and resident representatives who provide feedback on didactics and curricular needs.
- **The committee's duties.** The committee develops competency-based goals and objectives for each educational experience and makes them available to residents; integrates all ACGME Competencies and maps them to the Family Medicine Milestones; designs a broad range of structured didactics with protected resident time, including a regular evidence forum (journal club); verifies that required experiences, minimum hours, and encounters are scheduled and met; incorporates education in patient safety, quality improvement, integrated behavioral health, and pain management; and optimizes rotation continuity to minimize disruptive transitions.
- **Meeting frequency.** The committee meets monthly to maintain the didactic schedule and address curricular issues, plus a dedicated annual curriculum review timed to inform the Annual Program Evaluation.
- **Administrative support.** The Program Coordinator supports the committee (non-voting): maintaining the master didactic calendar and attendance records, version-controlling curricular documents, tracking completion of required experiences and hours/encounters for residents and the cohort, and recording minutes.
- **Reporting.** The Chair reports proposed curricular revisions and the annual curriculum review to the Program Evaluation Committee for approval, the Department Chair, and the Program Director. The Program Director distributes updated goals, objectives, and schedules. The committee coordinates curriculum–Milestone mapping with the Clinical Competency Committee. Curriculum review feeds the Program Evaluation Committee and the Annual

Program Evaluation, both of which are reported to the DIO and the **Graduate Medical Education Committee (GMEC)**.

5. Resident Wellness Committee

- The Resident Wellness Committee is a faculty and resident committee appointed by the Program Director to support your well-being, which is a shared responsibility of the program and the institution. It operates at the program level, addressing culture, scheduling, education, safety, and access to support. It never reviews or stores any individual's personal health information. Your care remains confidential and is accessed directly through institutional and clinical services.
- **Chair.** The committee is led by *the Associate Program Director for Behavioral Science Curriculum and Wellness*, appointed by the Program Director. The Chair oversees the program's well-being initiatives, ensures that required education and access to care are in place, and surfaces systems-level concerns to the Program Director.
- **Members.** Membership includes core faculty, a GME/EAP liaison, and resident wellness representatives, two per PGY where feasible, who represent the resident voice and channel anonymous feedback.
- **Committee Duties.** The committee oversees workload and work compression; evaluates workplace safety; sustains programs that promote well-being; ensures you can attend medical, mental health, and dental appointments, including during working hours; coordinates education on recognizing burnout and related risks among residents, faculty, and others, including self-screening tools; ensures access to confidential, affordable mental health assessment, counseling, and treatment, including urgent and emergent care; supports fatigue mitigation, adequate sleep facilities, and safe transportation; and ensures that needed leave is taken without fear of negative consequences.
- **Meeting frequency.** The committee meets monthly with additional sessions as needs arise, plus a dedicated annual review of well-being programming and aggregate climate data timed to inform the Annual Program Evaluation.
- **Administrative support.** The Program Coordinator supports the committee (non-voting) by scheduling meetings, recording minutes, helping disseminate well-being resources and self-screening tools, and tracking completion of required well-being and fatigue-mitigation education, all at the program level, without accessing individual health records.
- **Reporting.** The Chair brings systems-level recommendations and aggregate climate findings to the Program Director and the Department Chair. Aggregate well-being data feeds the Program Evaluation Committee and the Annual Program Evaluation, both of which are reported to the DIO and the **Graduate Medical Education Committee (GMEC)**. Individual support is always accessed directly and confidentially; it is never routed through the committee.

Participating Hospital Site

- **DCH Regional Medical Center**
Serves as the major participating hospital and receives GME funding from CMS.
A portion of this funding is provided to CCHS to support **resident salaries and benefits**.

IV. Accreditation

Accreditation Council for Graduate Medical Education (ACGME)

UATFMR is **accredited** by the ACGME, which oversees all allopathic and osteopathic residency programs in the United States.

- The program complies with:
 - *ACGME Institutional Requirements*
 - *Common Program Requirements*
 - *Family Medicine Program Requirements*
- More information is available at: www.acgme.org

American Board of Family Medicine (ABFM)

UATFMR also aligns with requirements set forth by the ABFM for board certification eligibility.

- Requirements include:
 - Continuity of care
 - Policies on leave of absence
- The ABFM administers the **In-Training Examination (ITE)** annually in the fall, which is a strong predictor of success on the board certification exam.
- The ABFM administers the Board certification exam biannually
- Previous ITEs and additional resources are available at www.theabfm.org

State Medical Licensing

The following regulatory bodies oversee licensure in Alabama:

I. **Alabama State Board of Medical Examiners (ALBME) Medical Licensure Commission of Alabama**

Residents must comply with all regulations regarding medical licensure. Detailed information is available at: www.albme.gov

Program Specific Policies

As previously mentioned, the Sponsoring Institution (SI) has an official Policy and Procedure Manual aligned with ACGME requirements. UATFMR has adopted the SI policies; however, the procedures to implement these policies are customized to fit the residency program. Additionally, there are some specific residency policies, procedures, and practices that apply directly to the residency program.

The Sponsoring Institution Policy Manual is available online and can be accessed through the CCHS Intranet. You may request a copy of any policy from the Residency Office at any time; however, it is the resident's responsibility to verify that the paper copy matches the most recent online version. The online version is regarded as the official policy.

Family Medicine Residency Policies – These policies apply to UATFMR residents in addition to the Sponsoring Institution's Policies.

- Clinical and Educational Work Hours Policy
- Moonlighting
- Professionalism
- Supervision and Accountability Policy
- Transitions of Care
- Well-Being, Fatigue Mitigation, and Monitoring
- Communications

Program Specific Practices

I. Clinical Practice

A. General Supervision

Residents must not independently perform procedures, treatments, or management plans for which they lack authorization, skill, or training. Communication of any significant patient care issues to the attending physician is the resident's responsibility.

Refer to: **Supervision Guidelines** on the Policies and Procedures page.

B. Communications

1. Cell Phones and Email

- Residents are expected to demonstrate professional and responsible communication behavior.
- The Residency Office, clinic staff, answering service, and rotation team members must always be able to reach residents, except when residents are on approved leave.
- Primary methods of communication include:
 - Designated team cell phone
 - Personal cell phone
 - Work email.
- **Refer to: Residency Communication Policy**

2. Faculty-Resident Communication and Feedback

- Feedback is provided during rotations, both in person and through end-of-rotation evaluations.
- Each resident is assigned an advisor for mentorship and to help set educational goals.
- Semiannual formative feedback is provided by the Clinical Competency Committee (CCC) based on ACGME Family Medicine Milestones.

C. Outpatient Clinical Duties

1. Continuity Clinic Patient Panel

- Residents are assigned a patient panel for the duration of their training.

- Panels are composed of patients from outgoing residents, new patients, ED/inpatient discharges, and family members of existing panel patients (upon request).

- **Clinic Schedule by PGY Level:**

PGY-1	PGY-2	PGY-3
1-2 clinics per week	3-4 clinics per week	4-5 clinics per week

Subject to change based on clinic and patient needs

2. General Expectations at UMC- Main and UMC-Northport

- Residents must arrive 15 minutes before the clinic start time for huddles.
- Notify the Residency Office and the suite charge nurse if running late.
- Clinic cancellation requests must be submitted 90 days in advance.
- Sick day cancellations require immediate personal notification.
- Residents must complete all paperwork, EMR tasks, and urgent messages by the end of each business week.
- Same-day appointments and late patients should be accommodated when possible.
- **All charts are expected to be completed before the end of the clinic.**
- Residents are not permitted to provide care or medications to family members.
- Residents are not allowed to serve as primary care providers for CCHS faculty, staff, or fellow residents.
- Patient access and accommodation is an institutional priority and supports resident education and advancement. Patient needs will remain the center of the clinical practice.

3. Precepting Expectations

- PGY-1 residents must present every patient to an attending for the first 6 months, and the attending must see all patients.
- Attending physicians must see all patients with Medicare, Tricare, Federal BCBS, or federal insurance.
- Residents must complete an end-of-clinic evaluation with their attending physician.
- All Medicare telemedicine visits require real-time interaction with the attending.

4. Protected Health Information (PHI) and EMR Use

- Compliance with all UMC/DCH EMR policies is required.

- Faxing should be limited and done securely.
- All releases of information must be documented.

5. Preceptor Expectations

- Attendings are required to personally see patients who are federally insured.
- Attendings must be present during all key portions of procedures.

6. Chart Completion

- Charts must be completed and sent to the appropriate attending within 72 hours.
- Residents will be notified of charts that are incomplete for over 48 hours.
- Unresolved charts may lead to removal from rotation and disciplinary review.

Refer to: Chart Completion and Authentication Policy

7. Billing and Charges

- Attendings are responsible for billing documentation.
- Uninsured patients should be referred to Social Services (205-348-7195).

8. Clinical Procedures and Protocols

- **Medical Transportation:** Only with attending approval; EMS only.
- **Patient Transfers:** Managed by nursing supervisor or Clinic Director.
- **Patient Dismissals:** Must follow UMC policy with attending approval.
- **Referrals:** Must be documented in the EMR with rationale.
- **Sensitive Exams:** Chaperone presence is required and must be documented.

9. Nursing Home Visits

- **Nursing Home Visits:** 36 visits required by end of PGY-3.

PGY-2	Must have performed and logged 9 nursing home visits by December 15th
PGY-2	Must have performed and logged 18 nursing home visits by June 15th
PGY-3	Must have performed and logged 27 nursing home visits by December 15th

PGY-3	Must have performed and logged 36 nursing home visits by June 15th
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II. Educational Practices

A. Professionalism

The ACGME has identified professionalism as a core competency essential to the clinical practice of medicine and resident development. The Professionalism Policy must be signed and submitted to the Residency Office at the beginning of training..

B. Curriculum Overview

Academic Year Structure

- The academic year is divided into **eight 6-week blocks**, further split into **three-week increments**.
- Separate schedules are created for **Thanksgiving week, Christmas week, New Year's week, and Spring Break week**.

PGY-1 Rotations

Call Rotations: -

- Family Medicine Inpatient (12 weeks)
- Medicine Night Float (3 weeks)
- Inpatient OB/GYN (6 weeks)
- OB Night Float (3 weeks)
- Inpatient Pediatrics (3 weeks)
- Ambulatory Pediatrics (6 weeks)
- Geriatrics (6 weeks)

Non-Call Rotations: -

- EKG/Vent (3 weeks)
- Surgery (3 weeks)
- Family Medicine Clinic (3 weeks)

PGY-2 and PGY-3 Rotations

Call Rotations: -

- Family Medicine Inpatient (18 weeks)
- Medicine Night Float (3 weeks)
- Inpatient OB/GYN (3 weeks)
- GYN Clinic (3 weeks)
- OB Night Float (3 weeks)
- Ambulatory Pediatrics (3 weeks)
- Inpatient Pediatrics (3 weeks)
- ~~Pediatric Night Float (3 weeks)~~
- One 3c-week Call rotation (Inpatient medicine or OB, Upper level, or Pediatric upper level). This rotation is

Non-Call Rotations: -

- Emergency Medicine (6 weeks total: 3 in PGY-2, 3 in PGY-3)
- Orthopedics (3 weeks)
- Sports Medicine (3 weeks)
- Psychiatry (3 weeks)
- Rural Medicine at UMC-Demopolis (3 weeks)
- Neurology/Cardiology (3 weeks)
- ENT/Urology/Ophthalmology (3 weeks)
- Practice Management/Community Medicine (3 weeks)
- Electives (27 weeks split between PGY-2 and PGY-3)

1. Rotations

A. Scheduling

- The curriculum spans **36 months**.
- The **Residency Office** creates an annual master schedule, which the Residency Director approves.
- **Rotation change requests** must be submitted **90 days in advance and preferably swapped with others**.

B. Elective/Subspecialty Rotations

- Residents must contact the **rotation preceptor 6 months in advance**.
- Elective choices must also be submitted to the Residency Office 6 months in advance.

C. Starting Dates

- Most rotations begin on the **first day of each block**.
- **Night Float rotations** begin at **4:15 PM** the night before the block starts.
- A full Master Schedule is provided before July 1.

D. Incomplete Rotations

- A rotation is **incomplete** if **<75% of business days** are attended.
- Rotation requirements must be completed within **30 days**; **failure** to do so may result in repetition.

E. Passing Rotations

- Residents must receive a **passing recommendation** from the Residency Director, Department Chair, or rotation preceptor.
- PGY-1s require a **“Ready for Upper Level”** recommendation to advance.
- The **Clinical Competency Committee (CCC)** advises the Director on decisions regarding promotions.

F. Away Rotations

- Must be discussed and approved by the Residency Director **6 months in advance**.

G. Rural Rotation

- Required: **3-week rotation at UMC-Demopolis**.
- Residents must return to a UMC FMP site for the continuity clinic.
- Stipends might be available through the Alabama Family Practice Rural Health Board (not guaranteed).

H. Supervised Practice Experience (SPE)

- Must be applied for **6 months prior**.
- Requires approval, an educational plan, preceptor agreement, and an ACGME-compliant environment.
- No funding provided by CCHS.
- The resident must stay current with documentation and patient volume.

I. Elective International Rotation (EIR)

- Allowed in PGY-2 and PGY-3; **must apply 6 months in advance**.
- Preceptor must be Board Certified (U.S.-based unless exempted).
- Written **proposal and summary** required.
- Reimbursement up to **\$1,500 once per residency**, subject to availability.

- University travel policies apply.
- **Note: EIRs and SPEs may be suspended at any time due to safety or institutional constraints.**

2. Conferences and Scholarly Activity

A. Academic conferences

- Held every Tuesday afternoon, mandatory attendance.
- Linked to promotion and program completion.
- Residents must attend unless they are on approved leave, restricted by duty hours, on an away rotation, or covering essential duties.
- Personal activities are not permitted during this time without prior approval.
- **Other Required Conferences Include: -**
 - Grand Rounds
 - Tuesday noon Conference
 - Morbidity & Mortality Conference
 - Journal Clubs
 - Emergency Medicine Series
 - Outpatient Teaching Series
 - Psychiatry grand rounds
- **Attendance is tracked;** residents are required to confirm their participation.
- **Unapproved absences** may result in disciplinary action and loss of annual leave.

B. Professionalism Expectations

- Phones and laptops must be turned off or set to silent mode during academic conferences.
- Laptop use is prohibited during lectures, unless approved for accessing learning materials.

C. Resident Forum

- Held quarterly during the Academic Afternoon.
- Open only to **residents and fellows** unless guests are invited.
- Provides a venue to raise program and work environment concerns.
- Concerns can be shared directly with the Residency Director or GMEC through resident representatives.

D. Behavioral Medicine Conferences

1. **Biopsychosocial Case Formulation Seminar (R-1 Presentation)**

- Required for all PGY-1 interns
- Interns are required to attend and present at the monthly Case Formulation Seminars.
- Minimum attendance requirement: **80%** to advance to PGY-2.

Seminar Format:

- Interns present a patient using the **biopsychosocial conceptualization model** (refer to the Psychiatry Family Medicine Curriculum Handbook).
- **Presentations are attended by:**
 - Interns
 - Psychiatry and Behavioral Medicine Faculty
 - Family Medicine Faculty
 - Participants provide feedback, ask questions, and offer suggestions.

Alternatively:

- Interns may participate in a **Balint-type group** led by Drs. **Thad Ulzen, John Burkhardt**, or other Psychiatry/Behavioral Medicine Faculty.

2. **Family Medicine and Behavioral Medicine Grand Rounds (R-3 Presentation)**

- Held **monthly** as a required component of the curriculum.
- Attendance is **mandatory** for all residents.
- Each **PGY-3 resident** will:
 - Prepare and present a **case-based Grand Rounds** presentation.
 - Engage in clinical discussion and interdisciplinary dialogue.

Preparation:

- Guided by **Dr. John Burkhardt**
- Supported by the resident's **Family and Behavioral Medicine advisors**
- **Orientation for presenters occurs in late May** prior to scheduled presentations.

E. Research and Scholarly Activity

1. Overview

- **All residents are required to participate in** scholarly and research activities **during residency. These activities are** mandatory for graduation.
- **While opportunities generally begin in PGY-2, interested residents may start as early as** intern year **by scheduling a meeting with** Dr. Louanne Friend, the **Research Director, to discuss opportunities.**
- **Scholarship incorporates four core areas of academic medicine (Boyer, 1990):**
 - **Scholarship of Discovery:** Original research
 - **Scholarship of Integration:** interdisciplinary work in which connections are made across disciplines.
 - **Scholarship of Application:** the application of theory to practice and the bidirectional relationship between theory and practice
 - **Scholarship of Teaching:** communication of knowledge to learners and the creation and sharing of knowledge about the practice of teaching.
- **Residents must accumulate 15 scholarly activity points to fulfill graduation requirements.**
- **All residents are required to complete one of the three types of projects listed below:**

- A. IRB Approved project
- B. Quality Improvement (*Please note: This is in addition to the required Performance Improvement projects focused on diabetes and hypertension*).
- C. Designing Enduring Curriculum.
- D. Other activities approved by the Research Director

- This 15-point system recognizes a variety of activities as scholarly; any of the four types of scholarship described by Boyer can earn points.
- Residents are encouraged to collaborate with each other and faculty on projects. Third-year residents are advised to include junior residents in projects that require ongoing evaluation. Please discuss this with the research director before graduation.
- Additional information regarding this requirement will be given during a formal orientation session at the beginning of PGY-2.
- All PGY-2 residents will schedule a meeting with the research director at the start of the academic year to discuss their scholarly projects.
- Residents are encouraged to collaborate with faculty from both CCHS and related disciplines.
- The research director must approve all projects.
- Residents who submit abstracts and are accepted for presentation at national conferences will be prioritized for travel support.

The following table provides an overview of the point system. The Research Director, Residency Director, and faculty mentor determine the specific number of points awarded for each project. For collaborative projects, full points may be awarded to each resident, or points can be distributed based on the level of contribution of each resident.

Approved Scholarly Activity Point System

	Maximum points
Completion of an IRB-approved research project	7
Completion of a Quality Improvement project	7
Acceptance (to peer review) of a manuscript describing a case report, clinical review, or research project; a systematic review to a medical journal; or a quality improvement project with evaluation	5
Publication of an edited book chapter or section	5
Acceptance (to peer review) of a manuscript describing a case report	5
Prepare an enduring curriculum for use by the residency program, including needs assessment; goals & objectives; activities/template; evaluation; and presentation for incorporation into the curriculum	5
Participating in a grant proposal or budget	3
Submission and acceptance of a podium or poster presentation at a state, regional, national, or international medical conference	3
Presentation of a podium or poster presentation at the CCHS Rural Health Conference	3
Participation in state, regional, or national committees of medical or educational organizations	3
Publication of a letter to the editor in a peer-reviewed medical journal	2
Publications for the lay public, such as newspaper articles, on medical topics or an article for the UA news	2
Submission without acceptance of a presentation at a state, regional, national, or international medical conference	1
Presentation of a podium or poster presentation at a local medical or patient care conference (includes but not limited to CCHS Resident Research Day, Grand Rounds, Scholarship Conference, etc.)	1
Special lecture outside of CCHS	1
Publication of an op-ed or letter to the editor in a local or state newspaper regarding a current public health concern	1
*Completion of CITI/IRB training and identification of an approved scholarly activity topic with a faculty mentor by the end of intern year	1
Presentation at Academic Afternoon (required for all)	1
Attendance of IHRH Rural Health Conference	1/day
Presentation of a one-hour lecture for Global Health Curriculum	1
Other activities deemed acceptable by the Research Director and Residency Director	As assigned

Other Scholarly Requirements

2. Quality Improvement

Quality Improvement (QI) is increasingly part of private practice through insurance-based pay-for-performance programs and annual American Board of Family Medicine Maintenance of Certification (MOC) QI Chart Reviews.

All residents must participate in a QI project.

- **This is a graduation requirement and is usually completed during PGY-2.**
- The goal of this requirement is to identify an improvement opportunity or performance gap, implement a change in care delivery, and assess the impact of that change.
- **The results of these projects must be submitted to the American Board of Family Medicine for approval of MOC points during PGY-2.**

All residents must complete both a hypertension and a diabetes PI/QI project.

3. Journal Club: Required During PGY-2

All residents must read and create a PowerPoint presentation summarizing a scientific journal article during their PGY-2 year. Journal articles must be approved by the Research Director and distributed to the class at least two weeks prior to the presentation.

Required Components of the Presentation Include:

- I. Introduction
- II. Validity of research question
- III. Relevant literature review
- IV. Methods
- V. Appropriate sample
- VI. Familiarity with commonly used statistical tests (e.g., chi-square, t test)
- VII. Measurement of validity and reliability
- VIII. Results
- IX. Discussion/conclusions
- X. Validity
- XI. Applicability to specific patients and populations

3. Library and Learning Resources

The Health Sciences Library is located on the ground floor of CCHS and is available to residents 24 hours a day.

4. Assessments and Evaluations

a. Evaluations of Faculty and Rotations:

- After each block, residents evaluate the faculty and rotations securely, anonymously, and electronically through New Innovations.
- To maintain anonymity, these evaluations are compiled every four to six months, and a composite average of the evaluations and comments is presented to the faculty.
- The evaluations remain fully anonymous.

b. Evaluations of Residents (Formative, Summative, and Final):

- After each block, rotation preceptors evaluate residents securely and electronically via New Innovations.
- Formative evaluations are made available securely and electronically through New Innovations four weeks after the block is completed.

c. Residents are assigned a faculty Academic Advisor to assist them in attaining their educational goals.

- Residents are required to meet with their advisor to discuss their evaluations for each quarter.
- Any deficiencies or areas for improvement should be addressed during this time. The advisor will complete a summative evaluation of the resident and submit it to the Residency Office and the Clinical Competency Committee.
- Advisors meet with their resident advisees before CCC meetings to discuss their evaluations and again, after CCC meetings to advise residents on milestone evaluations and progress.

d. The Clinical Competency Committee gives recommendations to the Residency Director regarding milestone evaluations of each resident and advises the Residency Director regarding resident promotion and graduation.

- Before the end of June, the Residency Director informs each resident of the decision reached, pending successful completion of the remainder of the academic year.

5. Documenting Procedures

- Residents should document all completed procedures in New Innovations within 30 days of completing them. Various procedures must be performed and documented to meet graduation requirements.
- Residents are responsible for documenting procedures promptly.

Procedural requirements are listed in the tables below.

Procedure Name	Comments	Required
Airway Management (intubation)	By June 30 of PGY-1	10
Cerumen Disimpaction	-	3
Circumcision	Except by prior statement of conscientious objection	5
Delivery of Bad News Discussion	at least 1 by June 30 of PGY-1	2
ECG	Perform	1
End of Life Discussion	at least 1 by June 30 of PGY-1	2
Fluorescein Exam		2
Hospital - ABG	Perform	3
Hospital - Adult Code/ACLS	Lead 2, Participate in 10	10
Hospital - ICU Patients	By June 30 of PGY-1	15
Hospital - Lumbar puncture	Observe/Perform	1
Hospital - IV Access (Venous)	Perform	2
IV – Ultrasound Guided	Perform	2
Nursing Home Visits – PGY-2	9 by Dec 15 / 18 by June 15	
Nursing Home Visits – PGY-3	27 by Dec 15 / 26 by June 15	
OBGYN - Contraceptive Subdermal Implant	At least 2 insertions, 1 removal	3
OBGYN – Continuity Deliveries		10
OBGYN – C-Section (Assist)		10
OBGYN – Vaginal Deliveries		25
OBGYN – Total Deliveries	Perform or Participate (80 for OB Track)	35
OBGYN - IUD (Intra Uterine Device)	Except by prior statement of conscientious objection	2
OBGYN - Wet Mount/KOH Prep	2 total	2
Ortho - Casting/Splints		4

Ortho - Joint/Tendon Sheath/Bursa/Ganglia/Carpal Tunnel Inj.	Includes all joints	10
Removal of Foreign Body	From Any Orifice	1
Skin – Biopsy/Excision	Punch, Shave, Scoop	4
Skin – Cryotherapy Destruction	Not Skin Tag	3
Skin - I/D Abscess		5
Skin - Ingrown Toenail		2
Skin - Laceration Repair		10
Skin – Tag Removal/Destruction		3
Inpatient Med Patient Safety Workshop Participation		2
Patient Safety Reporting Logged		5
Patient Safety Disclosures Logged		3

Requirements per PGY

Resident Requirements per Year for Advancement to Next PGY			
	PGY-1 Required by June 30	PGY-2 Required by June 30	PGY-3 Required by June 30
Continuity Clinic	200 hours for PGY-1	550 hours for PGY-2	1000 hours total for 3 years
Continuity Patient FMC Encounters	200	700- 750	1,750 (Includes a minimum of 100 Telemedicine Visits
Telemedicine Visits	20	30	100

Geriatric patients (Geriatric rotation and NH patients)	90		125
Continuity Total (FMC, NH, Home, Telemedicine Visits)	*	*	1,750
Total Deliveries	*	*	35 (80 residents on OB Track)
Vaginal Deliveries	*	*	25 (80 residents on OB Track)
Continuity Deliveries	10	*	10
C-Sections	10	*	10
Nursing Home Visits (Continuity Patients)	*	9 visits - Dec 15 18 visits - June 15	27 visits - Dec 15 36 visits - June 15
Journal Club		Coordinate with Research Director, present in Academics	1
Committee Attendance	*	75%	75%
R3 Presentation	*	*	1
Research Project Presentation	Identify project	Submit project abstract and poster by May 1	Present at a National conference
USMLE Step 3/ COMLEX Level 3	Must Register by March 1 st	Must pass by November 15 th Must have full license by Dec 31 (US Grads Only)	Must have full license by Dec 31 (IMGs)
Didactic attendance (This excludes Call coverage)	Must attend at least 75% of didactics for advancement to PGY- 2	Must attend at least 75% of didactics for advancement to PGY-3	Must attend at least 75% of didactics for GRADUATION
Board Exam Registration	*	*	By Dec 31

Board Exam	*	*	Spring exam
AMA GME CEP Modules (See handout)	PGY-1 Series I - Dec 1 Series II - June 1	PGY-2 Series I - Dec 1 Series II - June 1	PGY-3 Series I - Dec 1 Series II - June 1
ABFM MOC Points	*	*	≥ 50 by Dec. 15
KSA	<u>Asthma KSA</u> (Family Medicine Rotation) <u>Diabetes KSA</u> (Family Medicine Rotation) <u>Heart Failure KSA</u> (EKG Rotation) <u>Care of Older Adults KSA</u> (Geriatric Rotation)	<u>Musculoskeletal KSA</u> (Sports Medicine Rotation) <u>Care of Hospitalized patients KSA</u> (Gold Rotation)	<u>Care of Women KSA</u> (GYN Rotation) <u>Health Counseling and Preventive Care KSA</u> (Family Medicine Rotation)
QI Project (Performance Improvement Activity)	*	Diabetes QI Hypertension QI	*
cKSA (Continuous KSA)	EVERY QUARTER	EVERY QUARTER	EVERY QUARTER

ACGME Required Inpatient Encounters (as per Meditech report of resident signature)			
	PGY-1 Required by June 30	PGY-2 Required by June 30	PGY-3 Required by June 30
Adult Inpatients	*	*	750
ICU (Patients, not Encounters)	15	*	*
Emergency department patient encounters with children. (Pediatric rotation)	*	*	50

Inpatient encounters with children			50
Newborn Patients	*	*	40

6. In-Training Exam

The [American Board of Family Medicine](#) conducts the In-Training Exam (ITE) annually in the fall. Its goal is to evaluate each resident's progress and offer programs comparative data about their performance. The exam includes 240 multiple-choice questions and follows a content outline identical to the blueprint for the ABFM Certification Examination.

UATFMR aims to create an environment that encourages scholarship and lifelong learning. Therefore, preparing for the ITE and the Board Exam is given high priority.

The following criteria serve as internal benchmarks for UATFMR:

- PGY-1: 390 mean scaled score
- PGY-2: 410 mean scaled score
- PGY-3: 440 mean scaled score

Scores will be discussed with the resident's Academic Advisor and the Residency Director. If scores are lower than the internal benchmark, the Director of Learning and Evaluation will provide formal assistance with examination preparation.

Assistance with exam preparation will be provided through the remediation plan. (NOTE: This is NOT academic probation. It is expected that several residents may not meet this benchmark early in their training years. The goal of the remediation process is to identify those struggling with standardized tests and to provide formal support and training for improvement.)

A typical remediation plan will follow the procedures outlined below:

- Regular meetings with the Director of Learning and Evaluation.
- Regular meetings with the resident's Academic Advisor (at the advisor's discretion).

No academic probation will be issued solely based on the results of the ITE or follow-up test. The Residency Director will review the ITE results with confidentiality, professionalism, and consideration of the resident's overall development as a physician-in-training. Failure to collaborate with the academic advisor on the ITE may lead to academic probation.

III. Administrative Practices

1) Residency Agreement

The Trainee Agreement is issued before the start of initial training, only after trainees pass their pre-employment drug and alcohol screen and successfully complete any other pre-employment requirements set by the Program, College, or University. This agreement covers the entire training period, provided the resident receives a promotion letter to move on to the next years of training. Residents receive a copy of the fully signed agreement, with originals kept in the Residency Office for reference. After the initial agreement is signed, any renewal is communicated in writing to the resident. Residents who do not wish to renew their agreement must notify the Residency Office 60 days before the renewal date.

2) Benefits

The College of Community Health Sciences (CCHS) and the Capstone Health Services Foundation (CHSF) will provide the residents with the following (at the discretion of the sponsoring institution and based on the availability of funds):

- Advanced Cardiac Life Support Certification (ACLS)
- Pediatric Advanced Life Support Certification (PALS)
- Advanced Life Support in Obstetrics Certification (ALSO)
- Advanced Trauma Life Support Certification (ATLS)
- Alabama Academy of Family Physicians Membership (optional)
- Alabama Controlled Substance Certification Fees
- Alabama Medical Licensure Commission Fees
- Alabama State Board of Medical Examiner Fees
- AMA GME Competency Education Program (web-based program)
- American Academy of Family Physicians Membership
- American Board of Family Medicine In-Training Assessment Exam Fees

- American Board of Family Medicine Board Exam Fees
- DCH Regional Medical Center Meal Stipend – Provided on inpatient blocks. On-call residents receive \$147 per 3-week block, and night float residents receive \$189 per 3-week block. The total amount of funds available for the resident is placed on their card at the beginning of each academic year.
- DCH Regional Medical Center Medical Staff Privileges
- Educational Reimbursement (CME funds) – Up to \$1,000 for PGY-2 and PGY-3
- Laptop – PGY-1 residents are provided with a laptop for use during their residency training. Laptops must be returned to UATFMR before graduation.
- UWorld Study Subscription – PGY-1 residents receive a 180-day study subscription to UWorld for preparation for USMLE Step 3/COMLEX Level 3.
- Federal Drug Enforcement Agency (DEA) Certification Fees - One time only (Note: DEA Registration is valid for 3 years. Resident is responsible for renewal fees during PGY-3.)
- Lab Coats (2) and Scrubs (2)
- Occurrence-Based Malpractice Insurance
- Relocation Reimbursement – Up to \$1,500 (issued as a taxable sign-on bonus)
- University of Alabama Business Cards
- University of Alabama Parking Permit – Reimbursed to resident
- University of Alabama Staff ACT card
- USMLE 3/COMLEX Level 3 Application fees

Residents should promptly submit any bill or statement for any of the above to the Residency Office for payment.

The University of Alabama offers a range of employee benefits, with details available on the UA Benefits website. UA has also provided a Benefits Summary Guide, with a convenient one-page summary on page three.

Residents are responsible for completing the online benefit enrollment process within the first 30 days of employment. Failure to do so will result in ineligibility status until the official open enrollment period begins.

Residents are responsible for paying:

Alabama Academy of Family Physicians Resident Chapter Dues (optional)

Moonlighting Malpractice Insurance – PGY-2 and PGY-3, consistent with
Moonlighting Policy

DEA Renewal – PGY-3

3) UATFMR Leave Procedure and Guidelines

I. Overview

UATFMR follows the leave requirements established by the American Board of Family Medicine (ABFM) and the Accreditation Council for Graduate Medical Education (ACGME).

Important: Leave is not deemed approved unless a properly completed leave request has been submitted and signed by the Residency Director or their designee.

II. General Leave Guidelines

a. Minimum Attendance Requirement

- Residents must be present for at least 75% of business days during a block rotation.
- Absences exceeding 25% may result in an incomplete block, requiring remedial action or additional training.

b. ACGME-Compliant Time-Off Allowance

- Residents are entitled to 22 business days of vacation annually.
 - 10 days of Annual leave
 - 12 days of sick leave
- Programs must provide at least 6 weeks of paid medical, parental, or caregiver leave, which:
 - Does not count against vacation time
 - Is available regardless of FMLA eligibility (i.e., available for use through the three years of residency training)
 - Allowed for a total of 6 weeks during the three years of residency training.
- Leave usage must be tracked by the program and may affect board eligibility if extended.

III. Leave Requests

1. Submission Deadlines

- Leave requests must be submitted at least 90 days in advance.
- Requests submitted within 90 days require extraordinary circumstances and approval from the Residency Director.

2. Special Leave Periods

- **Leave during Primary Hospital Call Rotations**
 - Sick leave may be granted during primary hospital call rotations
 - Emergency leave may be granted at the discretion of the program director. Approval is contingent upon ensuring that patient care and service responsibilities are not compromised.
- **Minimum Attendance Requirement for Hospital Rotations**
 - To receive credit and successfully pass any hospital-based rotation, the resident must be physically present and actively participating in the rotation for at least 75% of the scheduled business days. Failure to meet this threshold may result in the rotation being marked as incomplete, requiring remediation or extension of training.

IV. Other Leave Types and Usage

a. Educational and Administrative Leave

- PGY-2 and PGY-3 residents may receive up to 5 days per academic year.
- Requires supporting documentation (e.g., conference brochure)
- Unused days do not carry over

b. Sick Leave

- Permitted for:
 - Personal illness/injury
 - Medical/dental appointments
 - Immediate family illness (as defined by institutional policy)
- Cannot be used as annual leave
- Once sick leave is used up, annual leave may substitute
- Prolonged illness may activate formal medical leave with documentation
- Sick leave is not carried over to the next year of training.

V. Clinical Duties and Coverage

1. Clinic Coverage

- Residents must arrange coverage for clinic sessions when requesting leave within 90 days of the scheduled clinic.
- Approval is at the discretion of the Residency Director

2. Required Notifications

- Residents must notify all the following upon leave approval:
 - Rotation preceptor
 - Family Medicine suite coordinator
 - Residency Office
 - Inpatient service (if applicable)
 - Assigned clinic

3. Leave Modifications

- Changes or cancellations must be submitted in writing
- Modifications may require re-approval

VI. Duty Hour Accountability

- Expectations During Duty Hours and assigned schedule:
- Residents must be either:
 - On assigned rotation
 - Attending the clinic or academic activities
 - On approved leave

VII. Board Eligibility Considerations

- Excessive leave may affect board eligibility.
- The Program Director will counsel residents if extended leave might require a training extension to meet certification requirements.

VIII. Total Time Away Across Residency Training

- Over the three-year residency, a resident may be absent from training for up to a total of 20 weeks without needing an extension. Provided that the clinical competency committee and program director recommend promotion to the next level of training and/or graduation.
- This allowance covers Family Leave that may take place in different academic years (e.g., the birth of a second child or ongoing personal or family-related leave).
- Out of these 20 weeks, 9–12 weeks (approximately 3–4 weeks per year) may be allocated through institutional allowances for time off, applicable to all residents.

- Program-specific and institutional leave policies and procedures will still dictate how this time is distributed and approved.
- Leave may extend across two academic years. In such cases:
 - The Program Director and the sponsoring institution retain the discretion to determine when the resident is ready to advance to the next Postgraduate Year (PGY) level.

IX. Time Allowed for Other Leave During Residency.

- In accordance with ABFM board eligibility policies, residents may take up to 4 weeks (30 days) of Other Leave (e.g., vacation, sick leave, educational leave, holidays) each academic year.
- In the absence of extended Family Leave, residents must complete 12 full months of training in each PGY year.
- Time off should be taken in accordance with the institution's standard leave policies.
- Residents may not:
 - Accumulate unused leave time to reduce the 36-month residency requirement or
 - Use future time off to retroactively make up for past absences due to illness or other reasons.

X. Residency Training Requirements for Board Certification Eligibility

Candidates for ABFM board eligibility must complete training in an ACGME-accredited Family Medicine residency program. In certain situations, the training may be extended to meet the minimum requirements. All residents should have core clinical training that covers the full scope of Family Medicine. For ABFM board eligibility, these include, but are not limited to:

1. Residents are required to spend their final two years of training in the same residency program's teaching practice to provide sustained continuity of care to a panel of patients.
2. Each year of residency must include a minimum of 40 weeks of continuity clinic experience. While this ACGME requirement has been replaced with "should" in the 2023 Requirements for Family Medicine Residency Programs, ABFM has elected to keep this a "must" requirement for board eligibility (exceptions may apply if the residency program has received a waiver of this requirement in connection with pilot projects assessing intentional variation in training requirements).
3. Beginning July 1, 2023, residents will be required to complete a minimum of 1,000 hours of "caring for one's panel".

At the end of training, the Program Director is expected to electronically sign via the Residency Training Management (RTM) system, on behalf of the Clinical Competency Committee, certifying that the resident has met all requirements for board eligibility and is prepared for autonomous practice.

4. Counseling and Support Services

Counseling and support services, including education information about substance abuse and physician impairment, are available to residents via the Residency Director. See also the [Sponsoring Institution's Impairment Policy](#).

<https://cch.ua.edu/education/sponsoring-institution-policies/>

5. Confidential Voluntary Self-Identification of Disability and/or Protected Veteran Status

The University's program of affirmative action invites employees to identify whether they are a covered veteran or an individual with a disability to receive the benefits of affirmative action. The information is used solely for affirmative action purposes and will not subject persons to any adverse treatment. Self-identification forms can be accessed at https://hr.ua.edu/wp-content/uploads/HR-Forms-Page/Voluntary-Self-Identification-of-Disability-Form_postHire.pdf.¹

Once employed, the University invites employees who fall into one of both categories to confidentially identify themselves by completing the Voluntary Self-Identification of Individuals with Disabilities and/or Voluntary Self-Identification of Protected Veterans forms that can be found on the Employee tab under Employee Services on myBama. Employees who have previously submitted this information do not have to submit it again unless their status has changed. Employees may contact the HR Service Center at 348-7732 with questions.

6. Severe Weather Guidelines

Enactment of severe weather guidelines will be governed by the University of Alabama's official closing decisions:

a. Tornadoes

Tornado watch refers to weather conditions which are favorable for tornado formation.

Tornado warning refers to a confirmed tornado in the area.

b. Severe weather coverage plan

- i. At Program Director's discretion, based off weather forecasts for the day, the severe weather coverage plan may be put into place. Should this occur, chief residents will contact residents on primary hospital services to help coordinate the coverage plan.

The expected coverage will be as follows:

1. The upper-level resident and intern who are scheduled to be on call when the severe weather plan is put into place, will be expected to remain in the hospital to provide patient care until night team is able to safely arrive.
 - i. If more than 1 intern and/or upper-level resident are scheduled for a severe weather afternoon, **ONLY** the primary call intern and on-service upper level are to remain in the hospital; all others should be dismissed at noon.
 - ii. In the event of an active **tornado warning** in effect until 9pm or later, the residents providing care should remain in the hospital overnight for admitting and patient care. The night team should be in communication with day team/chief residents and should plan to arrive at hospital once tornado warning is no longer active (**UNLESS AFTER 9pm**).
 - iii. If there is no active tornado warning at the time of the transition from the day team to the night team, the night team is expected to arrive on schedule.
2. If the day team residents must remain in the hospital overnight, rounding will occur as follows:
 - i. The off-service (geriatrics/peds clinic) interns will round in place of the interns who covered 24hr call the night before IF it does not interfere with their continuity clinic schedule; if the continuity clinic schedule precludes off-service residents from covering, residents from any other rotation may be contacted to fill in based on clinic schedule.
 - ii. The off-service (IM clinic/GYN clinic/Peds clinic) upper-level residents will round in place of the residents who covered 24hr call the night before IF it does not interfere with their continuity clinic schedule; in the event that continuity clinic schedule precludes off-service residents from covering, residents from any other rotation may be contacted to fill in based on clinic schedule
 1. Because there will be an extra off-service upper level for Peds/OB, residents are expected to work this out among themselves and the chief residents.
 - iii. It is expected that covering residents will receive formal checkout from the residents whose teams they will be covering.
 - iv. The off-service residents will be excused from their clinical duties (Other than continuity clinic) for the morning that they are covering to round and finish hospital work; they will be expected to return to their normal schedule for the afternoon

c. Snow and Ice

In instances where clinic is closed for snow/ice, those in the hospital should continue their normal call schedules and take extra time and caution when traveling; residents may consider utilizing call rooms at DCH.

If anyone feels unsafe to travel, they should discuss it with the chief residents and the program director.

7. Process for Confidential Reporting of Concerns or Unprofessional Behavior

Residents may submit an anonymous professional evaluation of peers, staff or faculty or submit a concern confidentially/anonymously through New Innovations or directly to the Residency Director. This is designed so trainees feel comfortable in reporting without concern.

The Residency Director will discuss the evaluation or concern with the Assistant Residency Director for Behavioral Medicine. Both the Residency Director and Assistant Residency Director for Behavioral Science will discuss the issue with the identified individual. The resident submitting the evaluation or concern will receive feedback from the Residency Director if they choose to disclose their identity.

If your concern is with a member of the residency leadership and you would like to report it outside of the process above, you may contact the DIO or the Senior Associate Dean for Academic and Faculty Affairs.

8. Chief Resident Selection

In addition to being a representative and leader among peers, the Chief Resident position entails numerous junior faculty-level administrative responsibilities, often requiring work outside of regular hours. The Chief Residents will typically be chosen in March–April.

The Chief Residents are expected to attend quarterly Department meetings at DCH. The complete transfer of responsibility will take place in May, following the match. The process for selecting Chief Residents starts with nominations and rankings by residents and faculty. The Residency Directors and FIRM Department chair interview the candidates and make the final decision, considering the rankings.

No resident will be considered for Chief Resident unless they are in good standing, as determined by the Residency Director.

The IT Chief will ensure that the hospital's resident computers and printers are maintained, troubleshoot resident issues with remote desktop and NextGen, and collaborate with DCH and UMC IT departments to improve our operating systems.

9. Committees

Residents will be assigned to committees at CCHS and DCH. Once appointed, **residents are required to attend committee meetings and actively participate**. After the residency training period ends, committee memberships become part of a physician's normal work environment. Learning how to be an engaged participant and contributor on committees is included in the training program and provides residents with an opportunity to demonstrate professionalism.

Residents should expect their participation on committees to be documented and included in regular discussions with their academic advisor.

10. Licensure

PGY-1 residents receive a limited license that allows them to practice only under the supervision of the program. After completing one full year of training and passing USMLE Step 3/COMLEX Level 3, residents must apply for an unrestricted license. This license must then be renewed annually. The program covers the application and renewal fees.

NOTE: International medical graduates are prohibited from obtaining an unrestricted license in the state of Alabama until they have completed PGY-2.

Residents who graduate from US medical schools must obtain an unrestricted medical license by January 1 of PGY-2. Those who graduate from international medical schools must do so by March 1 of PGY-3. Failure to secure licensure will result in probation until an unrestricted license is obtained and may lead to disciplinary action by the State Licensure Board.

11. Controlled Substance Certificates

Residents are required to obtain an Alabama Controlled Substance Certificate. Residents are also required to obtain a Federal DEA Certificate to prescribe controlled substances. The Residency Office submits applications for Federal DEA certificates when residents are issued a limited license.

The fees for the Controlled Substance and initial DEA Certificates are covered by UATFMR. DEA certificates are valid for three years. During PGY-3, residents are responsible for the DEA renewal fee. CME may be used to cover this fee.

No resident will be allowed to work without an active DEA certificate.

Signatures

I hereby certify that I have received, read, and reviewed the Sponsoring Institution policies and the University of Alabama Tuscaloosa Family Medicine Residency Handbook (which may be amended periodically by the University, CCHS and Program). I know these resources are maintained online and it is my responsibility to stay current via electronic access. I understand that I will be accountable for adhering to the policies and procedures both referenced and included herein and conducting my duties in the workplace in accordance with the information contained in this and other referenced policy manuals and/or handbooks.

Signature

Date

Printed Name