Notice

The Resident Handbook is a convenient first reference for general information regarding the College's major policies and regulations, facilities, and organization as they relate to graduate medical education (GME) and the residency programs. However, it is not intended as an exclusive reference manual for all University policies and procedures.

A complete posting of all updated and relevant general University policies is at: www.ou.edu/web/staff. Some of the policies included are the following: (1) Prevention of Alcohol Abuse and Drug Use on Campus and in the Workplace, (2) Discrimination, (3) Racial and Ethnic Harassment, (4) Sexual Harassment/Sexual Assault, (5) Consensual Sexual Relationships, and (6) Disability Accommodation. Grievance procedures for complaints such as discrimination, sexual harassment, or racial and ethnic harassment are also explained. A complete posting of updated School of Community Medicine policies that are specific to Graduate Medical Education is available at http://tulsa.ou.edu/socm/gmec.htm.

The information contained in this Handbook is current only at the time of publication and may change from time to time by the actions of the institution. Every effort will be made to ensure that the Resident Handbook is updated periodically. However, it is the responsibility of the user to determine that he or she is relying on the most current version of any particular policy. Up to date policies for GME and other important GME information are immediately available from the Office of Resident & Student Affairs. Questions concerning policies should be directed to the residency Program Director or the Office of Resident & Student Affairs.
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Introduction

Welcome to the University of Oklahoma School of Community Medicine. The School of Community Medicine, our residency programs, and our affiliated teaching hospitals have a long, respected tradition of excellence in clinical training. We believe you will find your educational experience and training at this medical center stimulating and rewarding. Our goal is to provide excellent preparation for your ultimate career in medicine.

Graduate medical education (GME) includes all of the medical, surgical and other specialty and subspecialty residency programs and fellowships offered by the University of Oklahoma School of Community Medicine and its affiliated teaching hospitals. Hereafter, all clinical training programs are referred to in this Handbook as residency programs. All clinical trainees, whether residents or fellows, are referred to in this Handbook as residents.

The School of Community Medicine and its affiliated institutions provide graduate medical education programs that meet the standards established by the Accreditation Council for Graduate Medical Education (ACGME) and its designated Residency Review Committees. The College’s institutional oversight of residency programs and residency affairs is conducted through the Graduate Medical Education Committee (GMEC) and the Designated Institutional Official (DIO).

As a physician in residency training, your primary responsibilities are participating in the educational aspects of your program and in the direct care of patients under the supervision of your Program Director and his/her faculty associates. The College provides a general orientation for new residents in late June. Your Program Director will also provide an orientation for you to the following: the organization and structure of your residency program including educational goals and objectives; duties and responsibilities; rotation, call, and vacation schedules; issuing of equipment (pagers, etc.); and a variety of other matters that are important to you during your time here.

Because of the complexity of graduate medical education and academic medical centers in general, administrative policies and procedures are necessary. The Resident Handbook has been compiled for your benefit and sets forth the guidelines that govern our residency training programs as well as certain regulations, benefits and policies. The Graduate Medical Education Committee and Program Directors, the affiliated teaching hospitals, the School of Community Medicine administration, and the Board of Regents of the University of Oklahoma are among those responsible for developing policies and procedures for GME. **It is your responsibility to become thoroughly familiar with the material contained in this Handbook.**

As stipulated in your residency agreement (contract), you are obligated to abide by the policies, procedures and regulations in the Resident Handbook and all pertinent GME and University policies. If you have questions concerning the information contained herein, please contact your Program Director or the Office of Resident & Student Affairs.
VERY IMPORTANT

All resident physicians new to The University of Oklahoma School of Community Medi-
cine must contact the Resident and Student Affairs Office immediately upon arrival in Tul-
sa and before reporting to a hospital or performing any official duties. Resident
physicians cannot participate in patient care experiences until their professional liability
insurance is in effect and a special license or a full medical license has been issued by
the Oklahoma State Board of Medical Licensure & Supervision or the Oklahoma State
Board of Osteopathic Examiners.

The statements, terms and provisions contained in the Resident Handbook are subject to
change at any time by the Board of Regents and/or the administration of The University of
Oklahoma, which expressly reserves the right to make any changes or to establish new
policies, rules and regulations from time to time as it deems necessary and proper. The
establishment of new policies, rules and regulations will be expressly for the purpose of
improving the quality of the resident's experience in his or her training program.
Resident Eligibility and Selection

Eligibility Criteria

Applicants for graduate medical education programs sponsored by the University of Oklahoma School of Community Medicine and its clinical departments are eligible for appointment if they meet one of the following qualifications:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education who have passed Step 1 and Step 2 CK and CS of the United States Medical Licensing Examination (USMLE). (No more than three attempts per USMLE step allowed by state licensing board.)

2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association who have passed Step 1 and Step 2 CE and PE of the COMLEX USA.

3. Graduates of medical schools outside the United States and Canada who meet each of the following qualifications:
   
a. Hold a valid Standard Certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), the requirements for which include passing both Step 1 and Step 2 CK and CS of the USMLE.

   b. Are citizens of the United States OR hold either a J-1 visa or a permanent immigrant visa (“green card”). An H1-B visa or Employment Authorization Document (EAD) in appropriate categories will be considered on a case by case basis with advanced approval in writing by the DIO.

Note: Non-U.S. Citizens who are graduates of medical schools in the United States and Canada are not considered international medical graduates and do not require ECFMG sponsorship.

Additionally, all applicants to residency programs will be considered only if, at the time of application, they are eligible for all of the following items:


2. Participation in Federally qualified health programs such as Medicare and Medicaid. A list of individuals with sanctions that disqualify their participation can be found on the Health and Human Services Office of Inspector General Website at www.oig.hhs.gov.
Issues that may preclude eligibility for the above items include, but are not limited to, prior felony convictions, substance abuse, malpractice judgments or settlements, or disciplinary actions by a state medical board.

Initial appointments and all reappointments of residents currently in GME programs to levels of training beyond the PGY-1 must meet the following:

1. Allopathic (MD) applicants or reappointments for the PGY-2 year must have passed Step 1 and Step 2 CK and CS of the USMLE and, at a minimum, possess a valid special license in the State of Oklahoma.

2. Allopathic (MD) applicants and reappointments at the PGY-3 and above levels must have passed Steps 1-3 of the USMLE and possess a full license in the State of Oklahoma. Failure of a current resident to obtain full licensure by the expected time of promotion to the PGY-3 year may result in immediate suspension or termination from the residency appointment.

3. Osteopathic (DO) applicants and re-appointments for positions of PGY-2 or above must have passed COMLEX USA Steps 1-3 and be fully licensed in the State of Oklahoma.

Selection Criteria
Residents are selected from among eligible, qualified applicants on the basis of their academic credentials, abilities, aptitude, preparedness, communication skills, and personal qualities including motivation and integrity. This University, in compliance with all applicable Federal and State laws and regulations, does not discriminate on the basis of race, color, national origin, sex, age, religion, disability, political beliefs, or status as a veteran in any of its policies, practices, or procedures. This includes but is not limited to admissions, employment, financial aid, and educational services.

First Postgraduate Year
First-year residency positions will be offered to US graduating seniors selected through the National Resident Matching Program (NRMP). Most residency programs require applicants to apply through the Electronic Residency application Service (ERAS). First-year residency positions offered to candidates other than U.S. graduating seniors will also be selected through an organized matching program, except in special circumstances allowed by national matching program policies. Applicants for these positions should consult the publications of the NRMP for specific requirements and deadlines.

Second Postgraduate Year and Above
Appointments for second year and above levels are made in accordance with policies established by each specialty program in compliance with the standards of the Accreditation Council for Graduate Medical Education (ACGME), its Residency Review Committees, and the requirements of the respective American specialty certification boards.
Selections for advanced level positions are generally made through an organized matching program when a matching program exists for the specialty or subspecialty. The PGY level of the initial appointment is determined by the amount of previously completed graduate medical education that is acceptable for credit by the specialty board of the training program to which the resident is appointed and the functional level at which training will be pursued. All previous GME training must be assessed and verified by the program director prior to appointment and assigning level of training. Whenever there is uncertainty in this regard, the applicant shall obtain from the specialty board a written appraisal of previous training and a statement of additional training requirements that must be met to qualify the resident for certification by that board.

**Graduates of Foreign Medical Schools**

Residency appointments for graduates of medical schools outside the United States and Canada may be offered only to those individuals who meet all requirements of Federal and State laws applicable to such appointments, including visa requirements. Such applicants must hold a currently valid Standard ECFMG Certificate prior to appointment, or have a full unrestricted license to practice medicine in a U.S. licensing jurisdiction in which they are training or practicing.

International medical graduate admitted to the United States for graduate medical education training under the authority of the University of Oklahoma School of Community Medicine must hold either a J-1 visa under the sponsorship of the ECFMG or a permanent immigrant visa (“green card”). An H1-B visa or Employment Authorization Document (EAD) in appropriate categories will be considered on a case by case basis with advanced approval in writing by the DIO.

Eligibility requirements can be found at [www.ECFMG.org](http://www.ECFMG.org). It is the responsibility of the applicant to complete all ECFMG requirements, visa requirements, and licensure requirements before beginning residency training. Failure to do so may result in immediate termination of the residency appointment.

**REQUIREMENTS FOR TRANSFERRING RESIDENTS**

Before accepting a transferring resident from another program, the OU Tulsa program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

Residents are considered as transfer residents under several conditions, including but not limited to moving from one program to another within the same or different sponsoring institution and when entering a PGY 2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY1 program and the PGY2 program as part of the match (e.g., accepted to both programs right out of medical school). The term ‘transfer resident’ and the responsibilities of the two program di-
rectors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

Examples of verification of previous educational experiences should include a list of rotations completed, evaluations of various educational experiences, and procedural-operative experience.

Meeting the requirement for verification before accepting a transferring resident is complicated in the case of a resident who has been simultaneously accepted into the preliminary PGY1 program and the PGY2 program as part of the match. In this case, the “sending” program should provide the “receiving” program a statement regarding the resident’s current standing as of one to two months prior to anticipated transfer along with a statement indicating when the summative competency-based performance evaluation will be sent to the “receiving” program.

GMEC approved: 4-1-2009 Policy #715
GMEC revision: 10-15-2009
**Residency Agreement**

Each individual offered a residency appointment will be provided with a contract known as the Residency Agreement. Each resident is expected to read, sign and abide by the Residency Agreement. The policies and procedures published in the *Resident Handbook* are referred to in the Residency Agreement and are applicable as stipulated in the Residency Agreement.

Residents are appointed for a period of one year or as specified in the individual Residency Agreement. **Renewal of any residency appointment is contingent upon the resident meeting the performance and attendance standards of the program and University, and is not automatic.** Intention by either party not to renew the appointment should be accompanied by appropriate notification as stipulated in the Residency Agreement. Under ordinary circumstances, four (4) months written notice of intent not to renew the agreement will be given. Notwithstanding the notice provision, the University may terminate the appointment of a resident or give notice of intent not to renew the appointment for academic or disciplinary reasons, or failure to appropriately progress within the four months prior to the end of the contract period, with as much written notice as circumstances will reasonably allow. See Administrative Academic Actions.

Please note: Residents are not allowed to begin work if they have not completed the Employment Eligibility Verification Form (I-9) within three (3) days of employment. Federal law requires this form, and failure to complete this form may result in termination. Failure to complete any other documents required by Federal or State law to confirm lawful presence in the United States may also result in termination.
Salary (Stipend)
Resident Benefits

Salary (Stipend)

A salary will be paid to each resident on a monthly basis. Salary levels are based upon the resident’s functional level of postgraduate training in the specific program in which he or she is currently training. PGY levels attained in previous training programs (if applicable) are not relevant to determining current salary level. Salaries are adjusted periodically upon review and recommendation of the GMEC and upon approval by the major affiliated institutions approved by the ACGME for residency training that provide funding for resident salaries. Checks for salaries are issued by the central payroll office of the University of Oklahoma Health Sciences Center (OUHSC) and are distributed by electronic direct deposit. Additional information about salary distribution will be provided to the resident by the Program Director's office.

Vacation Leave

Each resident earns a maximum of 15 days (M-F) of paid vacation leave per year. Training regulations imposed by the national certifying boards in some specialties may limit the amount of leave which may be taken by a resident to a lesser amount. Earned but unused vacation time may not be carried over from one academic year to another. No additional payment will be made for unused vacation upon completion of residency training or at any other time. The vacation request should be submitted to the program director at least 120 days prior to the requested date. No requests will be approved within 90 days of the requested date.

There is a legitimate need for Program Directors to limit the number of residents who are absent at any one time and to otherwise assure continuity of quality health care for the patients on their service. Vacation requests shall be honored according to the policy established by each residency program.

Sick Leave

Each resident earns a maximum of 15 days (M-F) of paid sick leave per year. Unused sick leave will not be carried forward to the next academic year. No additional payment will be made for unused sick leave upon completion of residency training or at any other time. Beyond the 15 days of paid sick leave, leave without pay is possible contingent upon recommendation by the Program Director and approval by the GME Office. The University complies with the Family Medical Leave Act.

Extended Leave of Absence

If the leave of absence is for personal reasons and not medical and the resident has accrued vacation leave, the leave of absence will be paid to the extent of the accrued vacation leave. Once the vacation leave is exhausted, the remainder of the leave of absence will be unpaid. If the leave of absence is for medical reasons and the resident has accrued vacation leave and sick leave, the leave of absence will be paid to the extent
of the accrued vacation leave and sick leave. Once the vacation leave and sick leave are exhausted, the remainder of the leave of absence will be unpaid. Any leave of absence without pay must be approved by the Program Director and the DIO. Benefits must be paid by the resident during the unpaid leave. A resident may not take a leave of absence longer than 30 days per academic year as long as the leave is not a qualifying FMLA event. Please refer to the Family Leave Policy regarding FMLA.

The University will continue to pay the cost of the University provided insurance coverage for employees for the 12 weeks of FMLA protected leave. The employee will continue to be responsible for payment of premiums for any elective coverage. It is the employee’s responsibility to contact Human Resources to determine premium payment requirements.

**Holiday Leave**

Residents do not receive credit or additional pay for holiday time during hospital rotations. Since hospitals do not observe a holiday schedule for patient care, residents are expected to follow their assigned schedule. If vacation time is scheduled during a holiday period, then the holiday must be scheduled as vacation. If the resident is assigned to a clinic that observes a holiday schedule, then the resident need not count that time toward his/her vacation time. Residents should check with their Program Director’s office for further clarification of holiday leave time.

**Educational Leave**

Residents may request up to five days of paid educational leave each year. The request should be submitted to the program director at least 120 days prior to the requested leave date. No requests will be approved within 90 days of the requested date. The meeting can be no more than one week in duration and must be within the USA. Approval is granted solely at the discretion of the Program Director, who also determines the travel reimbursement policy for the individual residency program.

Residents are encouraged to allow the department support staff to handle travel arrangements in order to maximize reimbursement potential. Commercial air travel must be booked by the resident’s academic department through approved travel agencies. There can be NO reimbursement for air travel unless an approved travel agency is used.

The resident must submit receipts for all claims, hotel bills, and registration fees to the department support staff within ten (10) business days of returning from the meeting. The staff will file the necessary travel reimbursement forms. Reimbursement will be based only on those items documented with receipts and in accordance with current departmental and University travel policy. **Please consult your Program Director’s office well in advance of attending any such event in order to obtain guidance on these matters.**

GMEC approved: 09-17-2009
GMEC revision: 04-17-2011
Family Leave Policies

Family Leave Guidelines
Federal law mandates that, after one year of University employment, qualified employees may take up to 12 weeks of leave (available paid leave and then unpaid leave) during any 12-month period for (1) the birth of a child; (2) the placement of a child for adoption or foster care; (3) the care of a spouse, parent, or child with a serious health condition; and (4) a serious health condition that makes the employee unable to perform the employee’s job functions. Contact Human Resources for additional information or visit hr.ou.edu for further information.

Resident Family Leave Policy
Depending on specialty board requirements, periods of family leave may extend the length of the residency training needed to meet specialty board requirements.

Maternity Leave
Available sick leave, vacation time, or leave without pay may be used in accordance with the Family Leave Act guidelines as described above. Specific questions should be addressed to the Program Director.

Paternity Leave
Available vacation time, or leave without pay, may be used in accordance with the Family Leave Act guidelines as described above. Specific questions should be addressed to the Program Director. Sick leave may not be used for this purpose.

Requests for Family Leave
Residency program schedule changes require considerable planning to assure that patient care and residency colleagues’ education are not impacted negatively. Therefore, requests for family leave should be made in writing to the Program Director as soon as the need is known.
Counseling and Psychological Support Services

1. Counseling and Guidance Services are provided by Student Counseling Services through the Office of Student Affairs. Services are provided by a licensed psychologist in a variety of areas: Individual, Couples, and Group Counseling, Consultation for Outreach Counseling, Improving Study and Test Taking Skills, Reducing Test/Evaluation Anxiety, Depression, Stress Management, Difficulty Sleeping, and many more areas. Information is available at 918.660.3109 or at www.ou.edu/content/tulsa/student_affairs/counseling/services.html. There is no charge for this program.

2. An Employee Assistance Program (EAP), providing evaluation, referral, and counseling is also available to all faculty, staff, and residents of OUCM-T through Family and Children’s Services, Inc. There is no charge for this program, and up to 6 visits per year are allowed for residents. Information is available from the Human Resources Office or the agency at 587-9471.

3. See the OU website for the Policy on Prevention of Alcohol Abuse and Drug Use on Campus and in the Workplace. The complete policy is also available upon request from the Human Resources Office.

4. Physician Recovery Program – The College recognizes the importance of providing intervention and treatment for physicians in residency and/or fellowship training who have alcohol or other chemical dependency problems. The College and its residency programs want residents to understand the administration’s desire to support their rehabilitation if they are discovered to have an alcohol or substance dependence problem.

The College has agreements with the OSMA’s PRP to deal with substance or alcohol problems and develop appropriate recovery programs.

The PRP is a program of the OSMA. The program’s purpose is to provide a peer-sponsored program for those physicians (including residents) who have developed an alcohol or substance abuse dependency problem.

The program approaches individuals suffering an alcohol or substance abuse problem with the following resources: (1) a method for confronting physicians regarding their problems, (2) mechanisms evaluating alcohol or substance abuse dependency problems, and (3) identifying appropriate treatment programs.

The PRP works with allopathic physicians, osteopathic physicians, physician assistants, dentists, residents, and medical students. The Oklahoma State Board of Medical Licensure and Supervision permits the OSMA’s PRP to supervise those individuals who voluntarily commit to its program and ongoing monitoring activities. To the extent permitted by the applicant and the law, the Board respects the confidentiality of the PRP.
Procedure for Residents
(Note: The following is the usual, although not the only, procedure for referring residents to the PRP.)

1. The residency program director contacts the OSMA PRP Committee to discuss options for dealing with a resident who is discovered to have a problem or potential problem.

2. The PRP committee meets with the resident and others who have corroborating information.

3. The PRP meeting is a “pre-evaluation” session, which normally leads to a formal multi-disciplinary evaluation, but it may lead directly to a treatment program.

4. The residency program director requires the resident to follow the PRP’s recommendations as a condition of continuation in the residency program.

5. The expense of these evaluation and treatment programs is the responsibility of the resident, but it may be covered partially by health care insurance.

6. The residency program can and should require periodic verification that residents continue in the PRP. Failure to continue in the PRP and comply with all terms and conditions of an after care program will result in termination from residency training.

7. The PRP includes a monitoring drug testing schedule. Residents who are participants in the PRP must submit to the program’s testing schedule. A “miss” in monitoring testing is considered a positive unless a satisfactory explanation is received from the individual scheduled for testing. The major testing site in Tulsa is the clinical office of William H. Yarborough, M.D.

8. After participating in the Oklahoma PRP, an individual can generally transfer to another state’s physician recovery program, if necessary

GMEC approved: 4-1-2009 Policy # 703
GMEC revision: 12-16-2010
Physician Wellness and Effectiveness

PURPOSE: OU Physicians-Tulsa is committed to providing patients with quality care and is aware of its obligation to protect patients from harm. It is well recognized that the delivery of quality health care is optimal when members of OU-Physicians-Tulsa are physically, mentally, and emotionally well. It is the intent of OU Physicians-Tulsa to:

1. Provide education to providers that addresses prevention of physical, psychiatric, emotional, or substance use related illness.

2. Provide a process that facilitates the confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition.

3. Educate providers on behaviors that may disrupt either the doctor-patient relationship or the relationships with peers and staff.

POLICY: The primary intent of this policy is to protect patients and staff; to rehabilitate providers when possible; and to increase the awareness of the faculty and staff in the recognition, and obligation to report health issues, that might impair performance. The focus of this policy is assistance and rehabilitation, rather than discipline, with the goal being to aid physicians in retaining or regaining optimal professional functioning, consistent with safe practice. If at any time during the diagnosis, treatment, or rehabilitation phase, it is determined that a physician is unable to safely perform the duties they have been granted, the matter will be forward to the Program Director (residents), the Chair, and the Dean for appropriate corrective action in conjunction with University policy as well as to state agencies as required by law. It is the expectation of the Dean and OU Physicians Advisory Board that referrals will be made to Physicians Wellness Committee when the issues described below are apparent.

PHYSICIANS HEALTH COMMITTEE: A committee of faculty will be formed with staff assistance. The committee will consist of a member of each department (if desired) that has an interest in issues of physician wellness. The committee will coordinate education in areas of physician health and review issues of behavior that may indicate impairment or disruptive physician behavior. The committee will meet regularly (at least quarterly) and report directly to the OU Physicians Advisory Board.

FUNCTION OF PHYSICIANS HEALTH COMMITTEE

1. The Physicians Health Committee will review incidents and concerns referred from the Dean, Departmental Chairs, Program Directors, Risk Management, staff members, and others. Ideally, the first portal for concerns should go through Departmental Chairs, or Program Directors, who then may decide, based on the concern, to refer the individual to the Committee. Individuals may refer themselves to the Committee or a committee representative. In all cases, confidentiality will be maintained, as long as the individual is following the recommendations of the Committee, and patient safety is not compromised.
2. The Committee will have the authority to require the individual concerned to meet with the full Committee or representatives of the Committee.

3. If the Committee determines that a potential impairment exists, the Committee will recommend to the Dean and Chair and Program Director (if applicable) options, including but not limited to:

   - Specific counseling or other health interventions, including referral to the Employee Assistance Program of the University.
   - Voluntary leave of absence to obtain appropriate evaluation and treatment necessary to address and resolve the issue at hand.
   - Limitations on the physician’s practice until appropriate evaluation and treatment has occurred. This may be voluntary or mandatory.
   - Suspension from clinical duties if the individual does not voluntarily adhere to the Committee’s recommendation.
   - Where appropriate, referral to the Oklahoma State Medical Association’s Physician Recovery Program will be made. The committee will act work with OPRP to assure compliance with evaluation and treatment as based on standards set by licensing agencies as well as the OPRP.

4. All recommendations will be forwarded to the Dean, Departmental Chair or Program Director (if applicable) for action. If the Committee feels the Departmental Chair is not appropriately carrying out the recommendations, the Committee may take the matter directly to the Dean.

5. The Committee will also review the treatment plans from the treatment providers and provide oversight in the monitoring of the treatment plan and compliance to the plan. The monitoring will generally be done by the OSMA Physicians Recovery Program, but the Committee may recommend additional monitoring if appropriate.

6. The Committee may also review new applicants to OU Physicians or residency programs on referral from the Credentials Committee, Chairs, or Program Directors who have had issues with impairment or disruptive behaviors and make recommendations back to those committees or individuals.

7. The Committee will provide educational programs to the Departments in issues of disruptive physicians and physician impairment.
DEFINITIONS:
*Impaired Physician:* A physician who is unable to practice medicine with reasonable skill and safety to patients because of a physical or medical illness, including deterioration through the aging process, psychiatric or emotional disorders, or substance abuse, to include alcohol or physical impairments.
*Disruptive Physician:* The issues involved here are the promotion of a safe, cooperative, and professional healthcare environment. Inappropriate conduct or behavior may lead to a “hostile work environment” for staff and other faculty. This in turn can create problems with performance of both staff and the physician. This behavior, may include, but is not limited to:

1. Threatening or abusive language directed at staff, or other physicians. This may include belittling, berating, or perceived threatening behavior.
2. Degrading or demeaning comments regarding patients, staff or the institution, particularly if done in a public setting.
3. Profanity or other offensive language while speaking with staff or other physicians.
4. Inappropriate physical contact.
5. Public derogatory comments about the quality of care being provided by other physicians, staff, or institutions that are used by the COM-T practice.
6. Inappropriate medical records entries concerning the quality of care being provided.

GMEC approved: 4-1-2009 Policy # 720
Parking

Parking is provided at no cost to the residents through the affiliated institutions. The Program Director or service chief makes parking assignments, depending on the location of a specific rotation. Residents are expected to abide by all rules regarding parking registration, hang tags, etc. Failure to do so can result in a citation with a fine or towing of your vehicle which is the responsibility of the resident.
Medical Library

1. The Library is located on the Schusterman Center campus, 4502 E. 41st Street, in Building 1 Hallway C near the Security Desk.

   Telephone: (918) 660-3220   FAX: (918) 660-3215

2. The purpose of the Library is to meet the informational needs of its users for patient care, education and research.

   Library hours:
   Monday – Thursday  8:00AM – 11:00PM
   Friday             8:00AM – 9:00PM
   Saturday           9:00AM – 7:00PM
   Sunday             1:00PM – 9:00PM

3. The OU-Tulsa library subscribes to over 400 journals in print and provides online access to nearly 18,000 full-text electronic journals. Almost all of the 15,000 books in the library may be checked out. The usual checkout period for students, faculty and staff is 3 months. Textbooks used by medical students for their rotations may be checked out for the length of rotation. Electronic versions of several hundred medical books are available thought the library’s online databases.

4. Library services include literature searching, document delivery. Books and articles in journals not owned by the Library can be obtained through interlibrary loan.

5. Material may be checked out and returned at the library's front desk. Requests for items the library does not own may be placed through the ILLIAD electronic interlibrary loan system. ILLIAD registration information is found on the library’s home page. Most articles are now delivered electronically, often within three to five days; material which comes in the mail will usually be available within two to three weeks.

6. Technology - The Library has twenty student computer work stations with Internet access and many software applications. For a list of the software, please visit http://tulsa.ou.edu/software.htm. Computer training classes are available throughout the semester. Participants can register at http://tulsa.ou.edu/it/training.htm. Printing, copying and scanning are also available. The library has full wireless connectivity, remote access to library resources and all students/residents have a home drive available for their use. The library has these electronic devices available to check out: eeePC laptops, flip video camcorders, DVD players (in-library use only).

Premier E-Resources - For , DynaMed is an evidence-based medicine clinical reference tool to be used at the 'point-of-care'. It lists clinically-organized summaries for over 3,000 topics and is entirely evidence-based. Free access to DynaMed is now being made available to physicians in the state of Oklahoma through the Oklahoma State Medical Association's web site. To access DynaMed from the OSMA home page, click on Professional Resources and then on the DynaMed link. You will need
your state license number to logon.

8. The library provides access to many excellent online e-resources including Medline, Ovid databases, Cochrane databases, MDConsult, Micromedex, Lexi-Comp, SPORTDiscus, ExamMaster and more. Most, not all, have full text articles ready to be printed. All can be accessed off-campus, excluding UpToDate. Presently, UpToDate is made available to residents through some departments. Online tutorials, database workshops, Ask-a-Librarian service and one-on-one individual instruction sessions are available to help you with these resources. Call the library anytime for assistance at 660-3220.

9. PDA and iPhone Applications - A list of PDA Applications will soon be posted on the library web site along with download links and instructions. Some of the applications are for DynaMed, Epocrates Rx, MobileMerkMedicus, PocketConsult (from MDConsult) and more.
**Personal Health Requirements**

Evidence of adequate immunization including measles, mumps, rubella, polio, and hepatitis B is required on initial entry into a residency training program or must be promptly obtained. Influenza immunization is recommended annually for individuals involved in providing care to high-risk patient groups. TB skin tests are required upon entry into a program and annually thereafter. If a resident reports a physician-documented positive TB skin test, he/she is exempt from further annual TB skin tests, but must follow the University’s tuberculosis policy regarding Mantoux conversion. The University’s tuberculosis policy was adopted pursuant to federal and state guidelines. Copies of the policy are available from the Office of Environmental Health and Safety.

Residents must also comply with all infection control and infectious exposure policies applicable to the medical staff in the affiliated hospitals and facilities to which they are assigned for rotations.

Familiarity with Occupational Safety and Health Administration (OSHA) requirements is essential and periodic instruction is mandatory. Compliance with "universal precautions" as defined by the Centers for Disease Control and institutional infection control practices is expected.

**Failure to comply with the above noted requirements may result in suspension or termination from the residency program.**
Instructions to Employees for
Reporting Work-Related Needle Sticks/Sharps/Exposure

The following is updated information about how to report a needle stick, sharps or splash exposure. Information and materials contained herein apply to Staff, Faculty, Resident Physicians, and most temporary personnel (those not hired through an agency). Employees including physicians are defined as workers hired to provide a service, and are not in business for themselves. Work related exposure is defined as occurring during the course and scope of employment. Needle stick or splash injuries from an unknown source, a source not known to be infected, or not suspected of having infection clinically, should be reported. However, generally, no medical prophylaxis will be administered.

You are responsible for reporting your injury to your supervisor and you are required to follow all medical instructions. Employees may NOT be evaluated, treated or referred to other OU-Tulsa Staff for any reason. Do not order lab or otherwise attempt to manage a blood exposure yourself. Safeguards in the system depend on the notification to Workers Compensation for appropriate management.

If you sustain an exposure by needle stick or slash injury, or prolonged exposure to damaged skin, report the exposure to your supervisor or attending immediately and complete the following steps:

- Wash site with soap and water. Antiseptic wash is acceptable, but not superior.

- Please report to one of the following clinics:

<table>
<thead>
<tr>
<th>MedCenter</th>
<th>MedCenter South</th>
<th>MedCenter Midtown</th>
</tr>
</thead>
<tbody>
<tr>
<td>2929 S. Garnett Road</td>
<td>10221 E. 81st St.</td>
<td>1623 S. Utica</td>
</tr>
<tr>
<td>Tulsa, OK 74129</td>
<td>Tulsa, OK 74133</td>
<td>Tulsa, OK 74104</td>
</tr>
<tr>
<td>(918) 665-1520</td>
<td>(918) 252-9300</td>
<td>918) 392-5100</td>
</tr>
</tbody>
</table>

  **Hours: Monday – Saturday 8:00 am – 10:00 pm / Sunday 11:00 am – 7:00pm**

- If you sustain the exposure at a teaching hospital, contact Employee Health Services at that facility. If the injury occurs after hours, on weekends or holidays, contact the facility’s Nurse Supervisor through the operator.

  Employees may NOT be evaluated, treated or referred to other OU-Tulsa Staff for any reason. Employees should use the above providers for any and all Workers Comp injuries/illness.

You must complete the “OU Employee’s Report of On-the-Job Injury/Illness”

Your supervisor/attending must complete the “OU Supervisor’s Report of On-the-Job Injury/Illness”.

If it is determined you need further assessment or treatment, MedCenter will make that determination and you are expected to follow the treatment protocol.

  Fax or email all forms as soon as possible to: Kim-Little@OUHSC.edu.

  Fax: 660-3200.
Professional Liability Insurance

Any graduate physician may be held liable by the law for accidents, errors, or omissions in professional judgment or professional acts uncommon to the practice of medicine in the community. All residents must make application for, obtain, and maintain professional liability coverage through the carrier designated by the University of Oklahoma School of Community Medicine. The College will provide an occurrence policy for supervised medical practice within the scope of the training program. Residents will receive necessary instructions from their Program Director regarding professional liability insurance. Terms of the professional liability insurance policy provided are available for review on the College website.

Note: Professional activities outside the scope of the residency training program are not covered by the residency program policy. This includes most so-called “moonlighting” activities. Residents engaging in any unsupervised professional activities must apply for and purchase, at their own expense, additional professional liability insurance covering these activities.

Residents that suspect that they might be named in any legal actions involving a patient, or have been notified of legal action, must immediately notify their Program Director.
Off Campus Electives

PURPOSE: To define criteria for approval of resident off campus electives that both enrich the educational experience of residents and limit liability and the impact of reimbursement to the institution.

Definition of an Off-campus Elective:
An educational experience that, due to the intended purpose, cannot be obtained at one of our major affiliated institutions and that is not part of the individual residency core curriculum. Generally, Off-campus Electives should be conducted in an ACGME-accredited Program, count toward residency requirements, and, if applicable, meet specialty board requirements.

Criteria for Approval
The Program Director is required to:
1. Demonstrate that the proposed rotation will provide a professional experience that is important for the resident’s education and enhances the individual resident's ability to meet specific career needs. Examples include exposure in an institution where the resident is seeking a subspecialty fellowship, exploration of career options, or an experience needed as preparation for a specific aspect of their planned career.
2. Demonstrate that the experience cannot be obtained at the OU College of Medicine or one of its major affiliates, and
3. Demonstrate that the experience will be appropriately supervised and evaluated by responsible faculty at the site.

Requirements:
1. The resident seeking approval for an elective must be in good standing in the program, (eg cannot be under academic remediation or on a corrective action plan)
2. The Program Director must provide a written Off-campus elective request for the Off-campus Elective which addresses the following:
   a. Educational objectives of the Off-campus Elective.
   b. Identification of the Off-campus Elective course director and supervising medical staff. Credentials and contact information for the course director must be included in the Memorandum of Understanding and the supervising medical staff must possess qualifications judged acceptable to the Program Director.
   c. Method of resident evaluation.
   d. Work schedule that is compatible with ACGME supervision and duty hours standards and includes specific start and end dates.
   e. Responsibilities of each party for providing appropriate educational experience, supervision, and evaluation.
3. Due to Visa restrictions, residents who have a H1B Visa will not be eligible to participate in Off-campus Electives, and those residents with a J1 Visa will only be eligible to participate after assurance that they can be in full compliance with University of Oklahoma and Federal policy.
4. Resident rotations outside the United States present concerns related to educational quality, clinical supervision, medical liability and workplace and personal safety. In general, Off-campus Electives outside the United States will not be allowed. For some international sites, OU has mitigated these concerns through formal inspection and affiliation agreements. In special circumstances where these concerns are adequately addressed, foreign electives may be allowed, but must meet all requirements for Off-campus Electives as well as have prior written approval from the OU COM’s Risk Management Office. In addition, the resident must show proof of appropriate health and travel/evacuation insurance coverage prior to approval and will be required to sign a waiver of liability.

5. The application must identify a verified source for funding the resident’s employment expenses, including salary, benefits, health and malpractice insurance, that is consistent with College and University policies. The College may consider supporting the resident’s salary and benefits if the experience meets the following conditions:
   a. The experience is a requirement for graduation of the resident
   b. The experience takes place within an ACGME program with full accreditation
   c. The experience is not available within OUSMC institutions and/or is a fellowship program where the resident intends to apply.

6. All duty hours must be accurately recorded in MedHub.
7. PG-1 residents are not eligible for off-campus electives.
8. Requests for the Off-campus Elective should be submitted to the Program Director at least 120 days prior to the requested date. No requests will be approved within 90 days of the requested date.
9. If approved by the Program Director, the request must be forwarded to the DIO at least 90 days prior to the requested date. No requests will be approved within 90 days of the requested date.

Checklist
1. Date of rotation/elective.
2. Off-campus elective request for the elective.
3. Confirmation of appropriate medical license for the elective site.
4. Confirmation of appropriate Medical Liability coverage for the elective site.
5. Confirmation of funding source for salary/benefits, malpractice insurance etc.
6. For international elective, confirmation of affiliation agreement, waiver of liability, health and travel/evacuation insurance, and approval of OUCOM Risk Mgt Office.
7. For residents on a visa, confirmation of eligibility via correspondence/approval of the OU Human Resources Department that deals with visa related issues.

GMEC approved: 4-01-2009 Policy # 728
GMEC revision: 4-15-2010
Securing Professional Liability Insurance for Approved Out-of-State Rotations

1. Residents approved to take an out-of-state rotation must apply for and receive verification of professional liability insurance that is underwritten for that specific rotation location and effective dates.

An Application for Resident’s Professional Liability Insurance for Out-of-State Rotations must be completed and submitted to the Residency Program Coordinator. (See attached.)

The professional liability insurance carrier requires 30 days to underwrite out of state rotations.

2. A separate application must be submitted for each rotation location.

3. The Residency Program Coordinator will submit the application to OU Physicians-Tulsa Credentialing Department via email.

4. OU Physicians-Tulsa Credentialing Department will forward the application to the Professional Liability Insurance Carrier for approval.

5. OU Physicians-Tulsa Credentialing Department will email the certificate of insurance to the Residency Program Coordinator, upon receipt.

6. The Professional Liability Insurance Carrier will indicate an amount of additional premium (if any) to be paid by the resident for each of the applications submitted. OU Physicians Professional Liability Coordinator will e-mail the Residency Program Coordinator the amount of any additional premium required for the rotation.

7. The resident will attach payment (personal check made payable to OUHSC Department of…) to the invoice and a hard copy of the application and return them to the Residency Program Coordinator for the coverage accepted. OU Physicians will bill the department for payment for this additional coverage.
THE UNIVERSITY OF OKLAHOMA SCHOOL OF COMMUNITY MEDICINE
Application for
Resident’s Professional Liability Insurance for Out of State Rotation

| NAME: ____________________________ (PLEASE PRINT FULL NAME) |
| MAILING ADDRESS: ________________________________ |
| CITY: ___________________ STATE: _______ ZIP: _______ |
| TELEPHONE: ___________ FAX: ____________________________ |
| DATE OF BIRTH: ___________ SSN: ____________________________ |
| SCHOOL/CAMPUS/RESIDENCY PROGRAM CURRENTLY ATTENDING: ____________________________ |

SCHOOL AT WHICH ELECTIVE IS TO BE TAKEN:

| NAME: ____________________________ |
| MAILING ADDRESS: ________________________________ |
| CITY: ___________________ STATE: _______ ZIP: _______ |
| TYPE OF RESIDENCY/SPECIALTY PROGRAM ATTENDING: ____________________________ |
| INCLUSIVE DATES OF ELECTIVE: ___________ 20_____ THROUGH ________________ 20_____ |
| REQUESTED LIMITS: $_______________ / $_______________ |
| APPLICANT SIGNATURE: ____________________________ |
| DATE: ____________________________ |

GMEC approved: 4-1-2009 Policy # 714
Oklahoma Medical Licensure

It is the responsibility of each resident to complete all licensure applications and documents in a complete manner in compliance with established deadlines. While this section reflects policies in place at the time of publication of this edition of the Resident Handbook, policies governing medical licensure and differing from those listed below may be enacted at any time by the respective medical licensing boards or by statute. Residents must be aware of and follow policies in effect at the time of any licensure question or issue. Residents will not be allowed to start their training program unless they are licensed. Failure to comply with (1) the medical licensure laws of the State of Oklahoma and (2) the institutional requirements regarding licensure shall be sufficient grounds for suspension and or termination of residency training. Up to date information regarding licensure is always available by contacting the respective board or visiting their websites as noted below.

Allopathic Physicians (M.D. Degree)
The Oklahoma State Board of Medical Licensure and Supervision (Board) licenses allopathic physicians to practice medicine in the State of Oklahoma. Residents in training programs must hold either a special license or full license issued by the Board as is stipulated in the section on eligibility requirements. The Board requires the United States Medical Licensing Examination (USMLE). Any applicant for licensure who fails any step of the USMLE three (3) times or takes longer than a ten (10) year period to obtain all steps of USMLE may not be eligible for licensure.

A. Special Licensure
Allopathic medical graduates in the first and second year of graduate medical education training in Oklahoma are required to have, at a minimum, special license for this purpose. All allopathic applicants must have passed both Step 1 and Step 2 Clinical Skills (CS) and Clinical Knowledge (CK) of the USMLE. A completed application with fees must be filed in time to allow issuance of the special license certificate by July 1st of the PGY-1 year.

The Board allows "no tolerance" on deadlines for licensure matters. A resident may not begin the PGY-1 or PGY-2 year or be placed on the payroll without having a special license. Individuals holding a special license may apply for a full and unrestricted medical license upon meeting all requirements for the full license.

B. Full Licensure
The law requires that applicants for full licensure possess a valid degree of Doctor of Medicine from a medical college or school located in the United States, its territories or possessions, or Canada that was approved by the Board or by a private nonprofit accrediting body approved by the Board at the time the degree was conferred. Applicants from international medical schools must possess the degree of Doctor of Medicine or a Board approved equivalent based on satisfactory completion of educational programs from a school with education and training substantially equivalent to that offered by the University of Oklahoma School of Community Medicine.

The law requires 12 months of progressive postgraduate medical training approved by
the Board. The law further requires graduates of international medical schools to have 24 months of progressive postgraduate medical training approved by the Board. All applicants must have passed appropriate examinations as stipulated by the Board (e.g., the USMLE Steps 1-3, National Board of Medical Examiners, or FLEX tests).

The Board considers each application individually and meeting the above criteria does not guarantee issuance of a license. Factors considered include, but are not limited to, examination results, educational background, post-graduate training, achievement in specialties, and personal history of moral and ethical conduct.

**Graduates of international medical schools must meet additional requirements.** A translator approved by the Board must translate documents not printed in the English language into English. If the Board is unable to verify information or has serious questions related to an international medical graduate applicant or the applicant’s medical school, it may reject the application. Applicants who are graduates of foreign medical schools must pass an English proficiency examination. Applicants who are not United States citizens must also provide written proof of ability to work in the United States as authorized by the United States Citizenship and Immigration Services.

C. Applying for a Medical License

Completion of the application process for either a full license or special license is the sole responsibility of the resident. Applications are detailed and include requirements for several documents and forms that must be mailed to the applicant's medical school, to examination boards for verification of scores, to any other institution in which the resident has completed any residency training, and to the licensing board of any other state in which the resident is currently or has been previously licensed to practice medicine. This procedure takes weeks, and occasionally months; therefore, residents are advised to obtain the necessary forms and begin the process as early as possible.

D. Licensure Board Address

At the time of publication of this Handbook, the mailing and website address for the Board of Medical Licensure and Supervision is:

- Oklahoma State Board of Medical Licensure and Supervision
  - P.O. Box 18256
  - Oklahoma City, OK 73154-0256
  - or
  - 5104 North Francis Avenue, Suite C
  - Oklahoma City, OK 73118
  - Telephone: (405) 848-6841
  - www.okmedicalboard.org

E. Institutional Policy for Allopathic Applicants

It is the policy of the University of Oklahoma School of Community Medicine that all allopathic applicants for residency positions must have passed both Step 1 and Step 2 CK and CS of the USMLE. All appointments at the PGY-3 level and above must have
passed Steps 1-3 of the USMLE and possess a full license in the State of Oklahoma. Failure of a current resident to obtain full licensure by the expected time of promotion to the PGY-3 year may result in immediate suspension or termination from the residency appointment.

Osteopathic Physicians (D.O. Degree)
Osteopathic physicians must meet the licensure requirements of the Oklahoma State Board of Osteopathic Examiners and must be licensed by July 1st of their PGY-2 year. No special license is required during the first year of graduate medical education training for osteopathic physicians. Many of the osteopathic board’s licensure requirements for documents and verifications are similar to those stated above for allopathic physicians. Accordingly, the applicant should begin the process as early as possible in order to meet all deadlines.

A. Osteopathic Licensure Board Address
At the time of publication of this handbook the mailing and website address for the Board of Osteopathic Examiners is:

Oklahoma State Board of Osteopathic Examiners
4848 N. Lincoln Boulevard, Suite 100
Oklahoma City, OK 73105-3335
Telephone: (405) 528-8625
www.docboard.org/ok/ok.htm

B. Institutional Policy for Osteopathic Applicants
It is the policy of the University of Oklahoma School of Community Medicine that all osteopathic applicants for residency positions must have passed Step 1 and Step 2 CE and PE of the COMLEX USA. All osteopathic residents must pass the final step of the osteopathic examination by the end of the first year PGY-1) of residency training.

Any osteopathic applicant considered initially for any clinical training position at the PGY-2 or above levels, must have passed COMLEX USA Steps 1-3 and be fully licensed in the State of Oklahoma.
**Prescribing Privileges for Residents**

**Including Narcotics Prescribing and Registration**

An OU resident who is properly credentialed by the hospital's medical staff office and whose signature is legible may write chart orders for medications, including controlled medications, for inpatients. In addition, the OU resident may write prescriptions for non-controlled medications on official prescription forms printed by the hospital for their inpatients who are being discharged. Prescriptions for controlled medications may be written on official prescription forms printed by the hospital by physicians in possession of current OSBNDD certificates.

Unlicensed physicians, such as Osteopathic PG-1/intern, may only write prescriptions on official prescription forms printed by affiliated teaching institutions or OU Physicians. These prescriptions must be signed by the unlicensed physicians and include their printed name and must include the printed name of the supervising attending or chief resident.

The resident must possess a current OSBNDD certificate in order to begin the PG-3 year and must maintain a current OSBNDD certificate throughout the remainder of residency. The OSBNDD will not give the resident a blank application form for state narcotics registration until the resident has a full Oklahoma medical license number. OSBNDD certificates expire three years from the last date of issue.

All residents are required by law to notify the DEA and OSBNDD of any change of practice address. Federal DEA certificates expire three years from the last date of issue. A renewal form is typically sent to the resident about 45 days in advance of expiration; however, the physician is responsible for contacting the DEA if a renewal notice is not received.

A physician may not write a prescription for any regulated substances in Schedules I through V, as defined by the Uniform Controlled Dangerous Substances Act, for the physician’s personal use. Prescriptions may be written only for patients established within a practice. Prescriptions must not be written for colleagues, friends and family, or others not established as patients of the practice. Violations of prescribing standards may prompt termination.

GMEC approved: 4-1-2009 Policy # 705
Resident Supervision in Graduate Medical Education

Supervision is the relationship between resident and supervising physician used in graduate medical education to educate and train resident physicians through reflection-on-action. This relationship is evaluative, extends over time, and has the simultaneous purposes of promoting the professional development of the resident while assuring the quality of professional services delivered to patients. Supervision is exercised through observation, consultation, directing the learning of the resident, and role modeling. Documentation of supervision is the written or computer-generated medical record evidence of a patient encounter that reflects the level of supervision provided by a supervising practitioner.

In a health care system where patient care and the training of health care professionals occur together, there must be clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or full-time staff. As resident trainees acquire the knowledge and judgment through experience, they must be granted increased autonomy in providing patient care. The following major principles shall be adhered to:

1. The University of Oklahoma School of Community Medicine – Tulsa (OU COM-T) programs follow the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting and certifying bodies.

2. OU COM-T affiliated institutions follow ACGME institutional requirements and maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other health care accreditation bodies.

3. Each affiliated institution must adhere to Oklahoma law and current accreditation requirements as set forth by the ACGME for all matters pertaining to the resident training program, including the level of supervision provided.

4. The requirements of the various certifying bodies must be incorporated into the OU COM –T training programs and fulfilled through local facility policy to ensure that each successful program graduate will be eligible to sit for a certifying examination.

5. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that a supervising clinician with appropriate credentials is available for supervision during clinic hours. Patients followed in more than one clinic must have an identifiable supervising clinician for each clinic. Supervising clinicians are responsible for ensuring that appropriate care is provided to patients in that clinical setting.

6. Affiliated training facilities must ensure that medical staff overseeing resident training provide reasonably appropriate supervision for all residents, as well as a duty hour schedule and a work environment that are consistent with proper patient care, the
educational needs of residents, and all applicable program requirements.

7. Supervising physicians must be immediately available to the resident in person or by telephone 24 hours a day during clinical duty. Residency program directors will assure that residents know which supervising physician is on call and how to reach this individual. Supervising physicians will exercise reasonable care in determining when a resident is able to function at the level required to provide safe, high quality, care to assigned patients and will have the authority to adjust duty hours to assure that patients are not placed at risk by physicians who are overly fatigued.

8. Supervising physicians are also responsible for determining when a resident is unable to function at the level required to provide safe, high quality, care to assigned patients and has the authority to adjust duty hours downward to assure that patients are not placed at risk by physicians that are overly fatigued.

Levels of Supervision and Responsibility

Each training program is constructed to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment. The determination and documentation of graduated levels of responsibility are outlined below.

1. Supervising Clinicians

Supervising clinicians are responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings, where applicable, such as long-term care and community settings. When a resident is involved in the care of the patient, the responsible supervising clinician must continue to maintain reasonable personal involvement in the care of the patient. A supervising clinician must provide a reasonably appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the resident and of the complexity of patient care needs.

The supervising clinician oversees the care of the patient and provides the appropriate type of supervision based on the nature of the patient’s condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. All services must be rendered under the reasonable oversight of the responsible clinician or be personally furnished by the supervising clinician.

2. Chief Residents

A. Chief Residents-In Training:

Chief residents in training, while usually in their last year of residency, are still considered residents and must be reasonably supervised by a supervising clinician.
Graduated levels of responsibility, however, may allow a wide range of practice.

B. Chief Residents-Post Training:

Chief residents post training may function either as a resident or as a supervising clinician, depending on the type of personnel appointment, salary level and source, and privileges.

Chief residents post training may be paid as trainees at a trainee salary scale and have resident appointments. To act as a clinician, practitioner however, they must go through an appropriate credentialing process and possess a full medical practice license. These chief residents are bound by Resident Handbook and resident supervision standards.

Chief residents post training, when appropriately credentialed, may countersign other resident and student notes, supervise other trainees, and function as independent practitioners within the specialty for which they have independent privileges.

3. Residents

The residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Each resident is responsible for communicating significant patient care issues to the supervising practitioner. Such communication must be documented in the record. Failure to function within graduated levels of responsibility, communicate significant patient care issues to the responsible supervising practitioner, or appropriately document the level of attending physician oversight may result in the removal of the resident from patient care activities.

In some cases, residents, including chief residents, have completed one residency program and are board eligible or board certified while enrolled in an additional residency training program. These individuals may at times be credentialed and privileged for independent practice, but only in the discipline of their board eligibility or certification.

Graduated Levels of Responsibility

As part of their training program, residents should be given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervising practitioner present or to act in a teaching capacity is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill.

Ultimately, it is the decision of the supervising clinician as to which activities the resident
will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.

The Residency Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. Graduated levels of responsibility will be in accordance with ACGME and JCAHO guidelines and made available by the Residency Program Director to other appropriate staff and affiliated institutional officials. The type of reasonable supervision required for residents at various levels of training must be consistent with the requirement for progressively increasing resident responsibility during a residency program, the application of program requirements of the individual department, and common standards of patient care.

Annually, at the time of promotion, and more frequently as appropriate, this document, along with a list of residents assigned to each year or level of training, will be provided to affiliated training facilities. The residency program director must include a specific statement identifying the evidence on which such an assignment is made and any exceptions for individual residents.

GMEC approved: 4-1-2009 Policy # 718
Resident Physician Responsibilities

Specific duties and responsibilities are assigned by individual Program Directors. Physicians engaged in the residency training programs of the College of Medicine-Tulsa are, however, generally expected to:

1. Develop a personal program of self-study and professional growth with guidance from the Program Director and faculty.
2. Participate in safe, effective and compassionate patient care under appropriate supervision that is commensurate with their level of advancement, skill, and responsibility.
3. Participate fully in the educational activities of their program and, as required, assume responsibility for teaching and supervising other residents and students as is appropriate.
4. Fully meet the performance requirements of the residency program.
5. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the affiliated institutions and hospitals.
6. Act by accepted principles of medical ethics and the ethical obligations of employees of a state agency and follow GMEC Policy Number 725 Relationships with Medical Vendors.
7. Participate in institutional committees and councils, especially those that relate to patient care review activities.
8. Participate in faculty and program evaluation, as well as department and institutional quality improvement activities.
9. Refrain from engaging in any outside employment or professional activities without written approval from the Program Director.
**GME Resident Commitment to the Teacher Learner Relationship**

The School of Community Medicine expects its learners to adhere to the highest standards of professionalism in their relationships with their patients, faculty, colleagues, and the staff of programs and institutions associated with their training. The official School of Community Medicine resident statement of commitment is as follows:

Resident Statement of Commitment

1. We acknowledge our fundamental obligation as physicians—to place our patients’ welfare uppermost; quality health care and patient safety will always be our prime objectives.

2. We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.

3. We embrace the professional values of honesty, compassion, integrity, and dependability.

4. We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability, or sexual orientation.

5. As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.

6. We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.

7. We recognize the need to be open and truthful with our patients, faculty, and colleagues about matters related to patient care, including medical errors that may affect the safety and well being of patients, the care team, or associated institutions.

8. We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.

9. We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
10. We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.

11. In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

GMEC approved: 4-1-2009 Policy # 724
Guiding Principles

1. All health care providers and staff are committed to patient-focused care and service.
2. Patients/consumers/clients are encouraged to take an active role in their health care and to freely discuss their concerns and symptoms.
3. All persons are treated with respect and dignity regardless of gender, race, national origin, religion, disability, sexual orientation, or financial status. We practice and provide services in a multicultural environment that is sensitive and aware of individual customs and life challenges.
4. All health care providers and staff strive to foster and promote collegial relationships with health care providers throughout the northeastern Oklahoma region.
5. The ambulatory clinic health care providers and staff apply customer-focused communication and interpersonal skills to exceed the expectations of patients, referring health care providers, payers, and managed care organizations.
6. All providers and staff are committed to promoting advances in health care through their services, research, and education.
7. The Universal Truths below will frame the relationship between our employees and our patients. Our patients are the most important reasons for being here; it is a privilege to care for them.
Universal Truths

All of our patients deserve:

A smile; A friendly greeting; To be addressed by name; Appropriate eye contact; To be comfortable and have minimal wait time; To have respectful and timely communication; To have team members who take personal responsibility for their needs, and who use professional behavior, dress (see dress code), and hygiene; A clean, orderly, and safe environment free of inappropriate language, rudeness, and conflict; To interact with staff who do not disparage the Clinic, the University, or each other.
**Interactions with Vendors**

**STATEMENT OF PURPOSE:**

The purpose of this policy is to assist OU School of Community Medicine faculty, residents, students and staff to maintain ethical working relationships with vendors in accordance with state ethics laws, federal regulations, guidelines of professional and industry organizations, and the ethical standards of medical professionals.

Responding to a public perception of bias in medical decision-making introduced by the interactions of medical personnel with vendors, the Accreditation Council for Graduate Medical Education (ACGME) in September, 2002, charged all residency training programs in the United States with developing policies to guide interactions of physicians and residents with medical vendors. More recently, the Association of American Medical Colleges (AAMC) published guidelines on “Industry Funding of Medical Education” with a target date for implementation of July 1, 2009. Additionally, the Pharmaceutical Research and Manufacturers of America (PhRMA) promulgated a new Code and restrictions on industry-physicians interactions, effective in January 2009.

**STATEMENT OF OBJECTIVE:**

The goal of this policy is to assist faculty, residents, students and staff of the OU School of Community Medicine to maintain high standards of professionalism that minimize risk of a conflict of interest.

**SCOPE:**

This policy applies to all members of the OU School of Community Medicine faculty, residents, students and staff when they are acting within the course and scope of their employment with the University or are otherwise engaged in providing professional services or representing themselves as a health care professional.

**DEFINITIONS:**

Vendor – any entity external to the OU School of Community Medicine that provides or may provide goods or services for administrative, academic, or clinical operations of the School. This includes but is not limited to: pharmaceutical organizations, home health care agencies, hospice organizations, durable medical equipment providers, laboratories, office supply (copiers, office equipment, etc.) organizations, and consultants.

**OPERATING PROTOCOL:**

A. Compliance with State Ethics Rules - OU School of Community Medicine faculty, residents, students, and staff are reminded that they are subject to the Oklahoma State Ethics Rules, which shall supersede this policy in case of a conflict.
B. Access - To protect patients, patient care areas, and work schedules, access by vendor representatives to individual physicians shall be restricted to nonpatient care areas and nonpublic areas and should take place only by prior scheduled appointment with or invitation of the physician.

C. Educational Programs - Presentations, educational programs, and training by industry representatives can provide useful scientific information and training to OU School of Community Medicine faculty, residents, students and staff. These presentations, programs, and training sessions require approval by the appropriate course or program director, medical director or chair and must explicitly exclude content that is mainly intended to market the vendor’s products or services. Gifts and meals provided in conjunction with industry sponsored programs are not allowed.

D. Continuing/Graduate Medical Education - Any financial support for Continuing Medical Education and/or Graduate Medical Education provided by a vendor must be given to the conference’s sponsor to reduce the overall conference registration fee for all attendees. It must be unrestricted and acknowledged by the CME sponsors. Other continuing medical education and/or graduate medical education activities, such as grand rounds and journal clubs, sponsored by the OU School of Community Medicine or its programs are expected to provide balanced, objective information. If complying with all the requirements for Category I CME credit is not feasible, the activities must meet the following basic guidelines and comply with University policy on regarding the promotion of another entity (Attachment 1- Memo from the Senior Vice President and Provost Ferretti, dated November 11, 2004).

1. Industry Support of Educational Activities- Financial support for educational activities may be accepted from vendors only in the form of unrestricted grants. Marketing presentations associated with the educational activity are not allowed. Corporate interests must have no control over the speaker(s) or content. Speakers shall provide full disclosure of all commercial relationships prior to the presentation. Speakers’ materials shall not be limited to those supplied by the vendor. If the speaker deems the materials to be of high quality and important to the presentation, they may be allowed as long as they are clearly labeled as provided by the vendor and the speaker discloses that fact. There should be no use of trade names in such materials. Any marketing activities, materials, or exhibits must be geographically and temporally separate from the educational activity. Corporate support for educational programs (such as resident retreats or orientations) must be fully acknowledged to all participants. Commercial support for any recreational or entertainment activities that are part of such programs is strictly prohibited.

2. Faculty, residents, and staff shall not allow their professional presentations of any kind, oral or written, to be ghostwritten by any party, industry or otherwise.

3. Scholarships to attend meetings or training seminars may be accepted by residency program directors or chairs when the company requires specific training before a product or device can be used.
4. Financial assistance by vendors for faculty, residents, students, and staff to support attendance at educational conferences is permitted provided that the selection of the meeting and the attendees is made solely by the University’s course or program director, or chair. Such funds shall be provided as an unrestricted grant to the course, program, or department and not provided directly to the attendee.

**E. Gifts** – No gifts shall be accepted from vendors. This includes books, reference manuals, training materials, promotional objects (such as pens, mugs, or notepads), meals, and recreational activities. Cash or cash equivalents, such as gift certificates, stocks, bonds, or frequent – flyer miles of any amount may not be accepted.

**F. Fees for Consultation Services** - Consultant fees may be accepted by OU School of Community Medicine faculty and staff for the provision of scientific, professional, or educational expertise rendered to industry, but they must be commensurate with the level of service provided. Contractual arrangements are governed by University and School of Community Medicine policies and applicable practice plans. These fees may not be accepted in exchange for merely attending a meeting or event or having a loosely defined association with a vendor.

**G. Promotional Speakers:** As outlined in the Senior Vice President and Provost Ferretti’s memo dated November 11, 2004, OU employees shall not serve as promotional speakers for a company’s products or services.

**H. Samples and Other Clinical Items** - Drug samples, patient education devices, products for direct patient care, and educational materials may be accepted solely for patient use. All pharmaceutical samples must be appropriately inventoried. Pharmaceutical samples and other patient care products provided by vendors are not to be dispensed for personal use by OU School of Community Medicine faculty, residents, students, and staff.

**I. Recreational Activities** – Attendance at industry-funded recreational or entertainment activities is prohibited, whether associated with approved educational activities or as separate activities. Industry support of attendance at approved educational activities by nonprofessional spouses or other guests is considered a gift and thus is prohibited.

**J. Food and Meals** - Meals will not be accepted by OU School of Community Medicine faculty, residents, students and staff except in conjunction with educational activities as outlined in item D.

**K. Formulary and Clinical Practice Committee Members** – OU School of Community Medicine faculty, residents, students, and staff who serve on committees dealing with pharmacy, formulary, equipment or device selection, or clinical practice guidelines shall disclose in writing to the committee membership any consulting or sponsoring relationships they have with any commercial entity during the time of their committee service and for two years after termination of the sponsoring relationship. Such professionals must recuse themselves from any committee decisions that may suggest conflict from their commercial relationship(s).
L. Research - Industry support for research activities is governed by existing policies of the University of Oklahoma,

M. Quid Pro Quo - No industry support of any type may be accepted in exchange for prescribing products, purchasing services, or providing business for or referrals to a vendor.

N. Administrative Enforcement - Each clinic's medical director and manager are responsible for sharing this policy with the clinic staff and for monitoring clinic faculty, residents, students, and staff comply with the policy. If instances of noncompliance with this policy cannot be resolved at the level of the clinic medical director and/or clinic manager, they shall be taken to the clinical department chair and/or the chief medical officer for administrative action.

O. Vendor Participation in Clinical Activities - At times it is required that a vendor be present in a clinical service area to assist with or instruct faculty, residents, students, and staff on the correct use of a product. This activity is allowed only when it has been approved by the appropriate institutional oversight body and in compliance with the associated policy and procedure related to the activity.

LEGAL/CONTRACT/OUHSC REFERENCE:
• Oklahoma Ethics Rules - http://www.ethics.state.ok.us/rules_03.pdf


• American Medical Association - AMA Medical Ethics Policy E-8.061 “Gifts to Physicians from Industry” http://www.amassn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-8.061.HTM&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-7.05.HTM&nxt_pol=policyfiles/HnE/E-8.01.HTM&

• American College of Physicians Physician – Industry Relations http://www.acponline.org/ethics/phys_ind.htm?hp


• AAMC: Industry Funding of Medical Education June 2008

Approved, OU SoCM College Leadership Group: March 24, 2009
Effective date: July 1, 2009
GMEC approved: 05-21-2009
Resident Evaluation and Promotion

Appointments to a Graduate Medical Education (GME) program sponsored by the University of Oklahoma School of Community Medicine are limited to a one year period of time. Shorter periods of appointment may occur in special circumstances. While it is anticipated that the majority of participants will gain reappointment and promotion through all required levels of training, initial appointment to a residency does not, in and of itself, guarantee promotion.

Residents are regularly evaluated by attending physicians and program directors regarding attainment of required competencies. In addition, many programs incorporate evaluation methods that include peers, nursing staff, and patients in the process. Other recognized methods that provide assessment of core competencies outlined by the Accreditation Council for Graduate Medical Education (ACGME) may be added and evaluated by programs in an ongoing fashion.

Evaluation of resident performance and competency occurs in many different venues including, but not limited to, inpatient unit activities, outpatient clinics, conferences, seminars, and journal clubs. Each program maintains appropriate documentation of evaluation and competency assessment and, as required by accrediting bodies, provides appropriate feedback to residents and completes summary assessments. The final determination of the adequacy of a resident’s performance and degree of competency rests with the faculty and program director.

Reappointment and promotion to a higher level of postgraduate training is based upon completing of all required curricular and program requirements for the current level of training, meeting the performance standards of the program, and demonstrating expected level of competency. In addition, candidates for any reappointment must meet all eligibility requirements as outlined in the OU School of Community Medicine policy number 716, Resident Eligibility and Selection.

Adverse actions affecting a resident’s status, including but not limited to leaves of absence, extension of training periods, or formal warnings or probation, must be communicated to the DIO or designee prior to institution of adverse action.

GMEC approved: 4-1-2009 Policy # 722
Resident Records and Retention of Records

The following documents shall be maintained in resident files during the period of residency training:

- Copies of a formal summative evaluation from any prior GME training (if applicable) assuring that the resident meets requirements for training at a particular PGY level
- Copies of signed contracts and letters of appointment.
- ERAS application
- ECFMG documentation
- Medical school diploma and/or medical school transcript.
- Copies of letters or memos to resident.
- Resident evaluation forms from attending physicians.
- Record of evaluation discussions with resident.
- Record of rotations schedule for resident, adequate to document completion of requirement for specialty boards.
- Special achievements.
- Scores of any required examinations that influence evaluation of resident.
- Record of procedural log as required by RRC, specialty board, or program.
- Record of any administrative academic actions as outlined in the Resident Handbook.
- Record of any disciplinary actions.
- Moonlighting requests

The following individuals have access to resident files:

- The individual resident.
- Program director and/or department chair.
- Program director’s administrative assistant handling resident matters.
- Any committee of the faculty designated by the program director to participate in resident evaluation and determination of promotion.
- The DIO for graduate medical education as required to handle administrative academic actions or disciplinary issues.
- Any person within the institution with a legitimate need for access.

The following documents shall be maintained in a resident’s permanent file following a resident’s successful completion of a training program:

- Copies of signed contracts or other documents indicating actual dates of service as a resident.
- ERAS application
- ECFMG documentation
- Medical school diploma and/or medical school transcript
- Record of rotations schedule for resident, adequate to document completion of requirements for specialty boards if such documentation is required.
• Summative evaluation of all training completed and preparedness for independent practice.
• Letters and summative evaluation provided to a training program regarding a transfer resident.
• Record of procedural log as required by RRC, specialty board, or program.
• Record of any attestation by program director to a specialty certification board of declaration of eligibility to sit for the certifying examination.
• Record of any formal administrative academic action as outlined in the Resident Handbook (if any exist, then the individual evaluations of the resident that are germane to the action should be retained).
• Record of any disciplinary action (if any exist, then the individual evaluations of the resident and other documents that are germane to the action should be retained).
• Moonlighting requests.

The following documents shall be maintained in a resident’s permanent file should a resident not successfully complete a training program:

• Copies of signed contracts or other documents indicating actual dates of service as a resident.
• ERAS application
• ECFMG documentation
• Medical school diploma and/or medical school transcript
• Record of summary evaluations.
• Record of rotation assignments if it is likely that the program director will need to provide this information to others in the future.
• Documents explaining the reason the resident did not complete the program (resignation vs. termination).
• Record of procedural log as required by RRC, specialty board, or program.
• Copies of any letters to resident indicating non-renewal of appointment, termination of training and reasons, anything else that may assist you later in explaining reasons for resident not completing program.
• Documentation of any administrative academic action as outlined in the Resident Handbook.
• Documentation of any disciplinary action.
• Moonlighting requests.

The length of time these documents shall be maintained and the format in which they shall be maintained is as follows:

• The permanent file, in its final form, should be maintained indefinitely.
• The program director may maintain files in hard paper form or by an appropriate image retrieval system.

GMEC approved: 4-1-2009 Policy #708
GMEC revision: 12-16-2010
Certificate of Training

Certificates of training for ACGME accredited residency programs are issued officially by the University at designated times and are requested through the Office of Resident and Student Affairs by the Resident Coordinator. Issuance of a training certificate requires documented evidence of completion of all requirements of the specific training program. Certification of completion of residency training will be provided only for those residents who have fulfilled all requirements established by their training programs, including fulfillment of time requirements.

Time away from the training program, regardless of circumstances, must be made up to the satisfaction of the Program Director before a resident will be considered to have completed his/her training program.

Certificates of residency training issued by the University are not equivalent to certification of attestation by the Program Director of eligibility to take the certifying examinations of the various American specialty boards. Certification or attestation of eligibility to take the certifying examinations of the specialty boards is done at the individual residency program level by the Program Director and implies exacting standards of excellence that have been met. Each specialty board defines these standards. Residents should consult with their Program Directors regarding specific board certification issues.

Certificates for non-ACGME accredited programs are issued as outlined in School of Community Medicine Policy number 702, Non-Accredited Graduate Medical Education Training, available on the GME website.

GMEC approved: 4-1-2009 Policy #727
Non-ACGME Accredited Graduate Medical Education Training

Clinical departments may offer training to resident physicians in a specialty area that is outside of the oversight of the Accreditation Council for Graduate Medical Education (ACGME). Non ACGME accredited training programs fall into two types. First are those that are accredited or overseen by an American Board of Medical Specialties board or medical society that provides standards for the curriculum and training experiences. The second type of training program is one where there is no accreditation process or oversight standards provided by an American Board of Medical Specialties or sponsoring medical specialty society. School of Community Medicine requirements for both situations are outlined below:

Accredited GME programs not overseen by the ACGME

The School of Community Medicine will sponsor GME programs that are accredited or overseen by a recognized specialty board or professional association that provides standards for a structured curriculum and set of training experiences. All such programs must be approved by the Graduate Medical Education Committee. Each program is expected to follow all GME policies and procedures of the School of Community Medicine including School of Community Medicine GME Eligibility Requirements, policy on duty hours, and moonlighting. Each program must maintain an appropriately credentialed Program Director with protected time sufficient to fulfill administrative and teaching duties, stable funding, an explicit and well-defined curriculum, and fully developed supervisory and administrative policies consistent with all other School of Community Medicine GME programs. Evaluation and promotion of residents must also follow standards consistent with all other School of Community Medicine GME programs. All participants are required to have formal Resident Agreements that outline the responsibilities of both the resident and the College.

Note: In order to maintain sponsorship by the School of Community Medicine, these programs must remain in good standing with School of Community Medicine Policies and Procedures and do one of the following:

1. Provide an up-to-date letter from the recognized specialty board or professional association that shows the program to be in good standing with meeting the requirements of accreditation or oversight. This letter must be provided to the Designated Institutional Official as soon as it becomes available and must clearly indicate the standing of the program and the period of accreditation that has been granted by the oversight body.

2. If a program cannot provide a letter of accreditation for any reason, the program must undergo periodic Internal Review by the Graduate Medical Education Committee on a review cycle that will be no longer than 3 years between reviews. The period of review may be shorter depending on the findings and decision of the Graduate Medical Education Committee after consideration of the review findings.
Non-Accredited Graduate Medical Education Training:

In order to sponsor graduate medical education programs where there is no formal oversight body, a clinical department has two choices. First, the department may elect to formally request that a non-accredited program be approved by the Graduate Medical Education Committee (GMEC) of the School of Community Medicine and function as an approved but non-accredited residency program under the School of Community Medicine. Secondly, the department may offer a course of additional training without developing a formal program. The following outlines the School of Community Medicine’s expectations of these relationships.

1. School of Community Medicine Sponsored Non-Accredited Residency Program

A sponsored non-accredited residency program is considered a formal residency program under the Graduate Medical Education (GME) Office and the GMEC. It is expected to meet all standards of accredited GME programs including a designated program director with protected time sufficient to fulfill administrative and teaching duties, stable funding, an explicit and well defined curriculum, and fully developed supervisory and administrative policies consistent with all other School of Community Medicine GME programs. If the focus of the non-accredited residency program is contained within the scope of education of an accredited residency or fellowship program at OUCOM-Tulsa, then the non-accredited residency program must be directed or co-directed by a full-time member of the faculty from the accredited residency or fellowship program, who possesses ABMS certification in that specialty. Evaluation and promotion of residents must also follow standards consistent with all other School of Community Medicine GME programs.

To maintain sponsorship, the responsible department must be in good standing with any associated professional societies. If the responsible department has other fully accredited programs, these must also be in good standing with those accrediting bodies. Oversight of program standards will be done through periodic Internal Reviews by the GMEC on a cycle of no longer than 3 years’ duration.

Trainees will be considered employees of the School of Community Medicine and will be assigned a contract similar to all other residents. They will be afforded the same rights and privileges and held to the same standards of conduct as all other residents as outlined in the Resident Handbook.

Formal GMEC approval of a non-accredited residency program is required, and the development of such a program must follow procedures outlined in the GME Policy on Proposed Residency Changes.

2. Additional Training
This arrangement occurs when a clinical department elects not to pursue development and maintenance of a formal non-accredited residency program as outlined above but still offers additional training to qualified professionals in a particular specialty. In this case, additional training should be offered only to individuals qualified to become faculty and should be only for a specified period of time. Such training cannot be offered if a formally accredited residency program is already in place for this particular specialty. The individual would be given an appointment as clinical instructor through the sponsoring department with the contractual arrangements set by the department. This arrangement would also require credentialing by all appropriate credentialing bodies for locations where the work and training would occur.

The sponsoring department must send a letter to the GME Office providing the name(s) of individual(s) receiving additional training. At the end of the period of training, the individual is eligible for a School of Community Medicine certificate of additional training for the period of time completed. Once the sponsoring department has sent a letter reflecting the information that should appear on the certificate, the GME Office will provide the certificate(s) which will state that the certificate verifies “additional training” and not use the term “fellowship.” The GME Office will also maintain a copy of this certificate.

All departments providing additional training opportunities must assure that the number of learners and the work done by them does not dilute the required experience of learners in the accredited and non-accredited residency programs sponsored by the department.

GMEC approved: 4-1-2009 Policy # 702
GMEC revision: 12-16-2010
Appointment of Advanced Residents to Faculty Positions

Residents and fellows in the College’s graduate medical education training programs are generally NOT eligible for faculty appointments.

However, each year there will be a few instances in which residents and fellows who are taking training beyond that required by the ACGME or certifying board and they provide specific teaching and other services which may qualify them for a modified faculty appointment.

1. Residents and fellows may be appointed only as volunteer faculty with the title of Clinical Instructor.

2. Additional funds for teaching or other services paid to the resident/fellow above the standard GME stipend are processed as Special Pay requests.

3. No TRS or TIAA-CREF benefits are available for resident or fellow appointments.

4. Any exceptions to this policy must be approved by the Dean’s Office.

GMEC approved: 4-1-2009 Policy # 704
Resident/Fellow Appointment Stipend Levels

A salary will be paid to each resident on a monthly basis. Salary levels are based upon the resident’s functional level of postgraduate training in the specific program in which he or she is currently training.

GMEC approved: 4-1-2009 Policy # 707
Notice of Release of Personal Information

In compliance with the Family Educational Rights Privacy Act, the School of Community Medicine is periodically required to provide “directory information” concerning residents/fellows to Medicare, Office of the Inspector General, and other designated authorities for the purpose of auditing costs of graduate medical education.

“Directory Information” as stipulated in the law includes: name, address, telephone listing, date and place of birth, major field of study, dates of attendance, degrees and awards received, and the most previous educational agency or institution attended.

The School of Community Medicine will also distribute picture rosters to the OU Tulsa School of Community Medicine departments and the affiliated hospitals where the residents may be assigned.

GMEC approved: 4-1-2009 Policy # 706
Verification of Training

Each department will prepare a final letter of recommendation/confirmation of training at the end of each resident’s training and will include all the pertinent information that credentials offices need. This letter will be sent to the Office of Resident and Student Affairs to be kept in a permanent file of resident information.

All requests for information will be answered by the Office of Resident & Student Affairs with a copy of this letter of Verification of Training and a standard cover letter that indicates the letter is a copy of the original. This is the only information that will be provided, with the exception of forms required by state licensing agencies.

GMEC approved: 4-1-2009 Policy # 729
Medical Records

Properly maintained and completed medical records are of the utmost importance in caring for patients and also serve as a basis for some clinical investigative work. Therefore, great emphasis is placed on the preparation, maintenance and preservation of medical records in the hospitals and clinics. Although computerized clinical information systems continue to expand in all our patient care facilities, there is still great use of and dependence on written medical records. Accordingly, residents should be aware of the rules and regulations regarding medical records.

Specific rules concerning medical records vary with the different services and hospitals, and each resident is responsible for the instruction of junior residents on the service in these rules. General rules apply to all services, and they are:

Preservation of Medical Records

1. No medical record may be removed from the files without a proper sign-out of the record to show where it has been taken and who is responsible for it.
2. If a medical record, subsequent to its removal from the files, is transferred from one person to another, it is the responsibility of the person to whom the record is charged to notify the appropriate Medical Records Department.
3. Medical records must not be taken from the hospital or clinic.
4. Medical records of patients previously treated are available to residents for approved education or research purposes, subject to any hospital or clinic policies.

Preparation and Maintenance of Medical Records

1. A complete history and physical examination must be written or dictated within 24 hours after admission of each patient, or within the guidelines determined by the hospital’s medical staff executive committee.
2. Adequate, up-to-date, and legible progress notes must accurately reflect the patient's hospital course and clearly outline the supervision of attending faculty.
3. Residents must date and sign each entry made in the clinical record assuring legibility of the resident's name.
4. Abbreviations may only be used as per hospital or clinic policy.
5. Each patient has a unique medical record number. This identifies him/her for all medical purposes. The medical record number must be placed on every sheet of the record and on every form requesting ancillary services. Generally, a pre-printed sticker will be available for this purpose.
6. When it is known that a patient is to be discharged, all residents responsible for the preparation of items in the record must attempt to complete those items before the patient leaves the hospital.
7. The service discharging a patient is responsible for the summary of the patient's entire hospitalization in dictated form.
8. Residents on duty in an emergency department must complete the medical record immediately after a patient is treated. Emergency department records are needed by many. The record must not be taken elsewhere; if copies are needed, photocopies will be prepared by emergency room staff according to policy.
9. At regular intervals, appropriate hospital committees will review medical record
delinquencies and deficiencies, including those of residents. **Serious deficiencies will be reported to the appropriate Program Director for administrative action.** The Executive Committee of the Medical Staff may also levy sanc-
tions that restrict a resident’s activity in that facility.

**Confidentiality of Medical Records**

1. Residents are cautioned that medical records are confidential. The use and dis-
losure of the health information contained in a medical record are restricted by
the regulations (Privacy Regulations) promulgated pursuant to the Health Insur-
ance Portability and Accountability Act (HIPAA) of 1996 and state laws.

2. Residents must comply with the University’s Privacy Policies and Procedures
(Privacy Policies) implementing the Privacy Regulations. The failure to comply
with the Privacy Policies will result in corrective action, up to and including termi-
nation from the program.

3. Residents must make reasonable efforts to safeguard medical information. For
example, residents must not discuss particular patients in public or leave medical
records in places where unauthorized persons could access them.

4. Residents must abide by all University policy if storing health information on port-
able devices.

5. Residents must comply with all policies developed by the University related to the
security of health information.
The University of Oklahoma Health Sciences Center and the School of Community Medicine have no formal dress code for residents. However, given the special nature of dealing with patients and their families, there are certain guidelines that are appropriate.

Professional appearance and demeanor are a demonstration of respect for the patient and the profession, and of self-respect. This professional appearance and demeanor should be maintained at all times by faculty, residents, and medical students. Individual programs will inform residents of standards or requirements unique to that department or program. The resident must abide the prevailing standards of the facility.

In general, clothing should be clean and in good repair. Blue jeans, shorts, t-shirts, hats, and exercise clothing are not acceptable. Hair should be kept well groomed and neat. Mustaches and beards should be neatly trimmed. A clean clinical jacket, or other professionally appropriate attire, must be worn at all times while on duty. Name tags are issued to each resident and must be worn for identification by patients, families, hospital, and clinic personnel.
**Equipment**

Residents may be assigned pagers, keys, electronic pass cards, parking cards, and other equipment or items as deemed necessary. Residents are responsible for the equipment originally assigned to them by the program and must not exchange their equipment with other residents unless authorized to do so by the Program Director. If equipment malfunctions, it must be returned to the department for exchange or repair.

Pagers will be issued, returned for repairs, exchanged, logged, and checked in, in accordance with the policies of the individual residency programs. In the event of loss or destruction, the resident to whom the equipment was assigned is responsible for the replacement cost of the pager.

Before a resident completes or leaves an OU School of Community Medicine training program, the equipment, keys, and other items assigned to the resident must be returned in good working order by the last working day.
Institutional Policy on Resident Duty Hours

1. Duty hours must be consistent with the respective Residency Review Committee Program Requirements and current ACGME Institutional Requirements that apply to all programs. Each program must document compliance with the duty hours policy of its specific RRC. The current duty hours policy is available on the ACGME website at: www.acgme.org

2. The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations.

3. Each residency program must implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting.

4. Each residency program will assure timely resident reporting of duty hours via the MedHub residency management system and formally monitor resident duty hours for compliance. Program will provide prompt and accurate responses to concerns raised by the GMEC as part of its institutional monitoring program.

GMEC approved: 4-1-2009 Policy # 709
GMEC revision: 12-16-2010
Resident Moonlighting

Moonlighting is defined as any professional medical activity outside the usual training experience and includes both compensated and uncompensated (e.g., voluntary) activities. The OUCOM-T and program directors must closely monitor all moonlighting activities to insures that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Therefore, residents must obtain prior written approval from their program director to moonlight and must submit all moonlighting hours into the duty hours tracking system. Unsupervised moonlighting (a.k.a. “external moonlighting”) refers to professional medical activity engaged in by the resident outside the context of the residency program and where the resident in effect acts as an independent contractor. Some residents may choose such work in their free time to supplement their incomes or to incorporate experiences not otherwise found in their formal training programs. This practice can be beneficial to the individual if prudently employed. If abused, however, patient care may suffer, the training program for the individual may be impaired, and the burdens imposed upon peers may become excessive. Some residency programs strongly discourage moonlighting activities, while other programs accept such activities as long as they do not compromise the resident’s ability to meet his/her obligations to assigned patient care and to satisfy program performance requirements. A resident may not, however, under any circumstances open or work in a self-owned private practice office while in training. Professional liability insurance coverage for unsupervised moonlighting is not provided under standard coverage provided for residency education and is fully the responsibility of the resident. Supervised Moonlighting (a.k.a internal moonlighting) is fully supervised patient care that is done over and above the usual program training experiences and is for the express purpose of additional elective supervised training. The Program Director must assure that all such activities are fully supervised and evaluated in accordance with all applicable College and affiliated institutional policies on resident supervision including clear documentation in the medical record of the supervision provided. Though there may be extra compensation for this activity, the activity is considered supplementary to the resident’s formal training and is not a substitute for the formal core curriculum. Professional liability coverage for supervised moonlighting is covered under the resident’s policy for residency training. All supervised moonlighting activities provided by a program must be approved in writing by the DIO prior to being implemented by a program.

No resident of the University of Oklahoma School of Community Medicine - Tulsa may be required to engage in moonlighting activities, either unsupervised or supervised, that may be needed to cover services within the affiliated institutions. Supervised moonlighting within the context of the residency program, as well as unsupervised moonlighting that occurs within the sponsoring institution and its affiliated clinical training sites, must be counted toward the work hour limitations set by the Accreditation Council for Graduate Medical Education.

As stipulated in the residency contract, residents agree not to engage in any moonlighting activity without the explicit knowledge and prior written approval of the residency’s Program Director. This written approval must become a part of the resident’s file. Based
on these limitations, the discretion of the program director, and/or resident’s perfor-
mance in the program, the Program Director will inform the resident in writing of any
limitations on his or her moonlighting activities.

Any type of moonlighting without the knowledge and prior written approval of the Pro-
gram Director is considered grounds for immediate dismissal from the training program.
Residents must also be monitored by the Program Director for the effect of moonlighting
on their performance. Evidence of adverse effects will be considered grounds for with-
drawal of permission to moonlight.

The independent practice of medicine without licensure and appropriate credentialing is
illegal. In Oklahoma, residents must satisfactorily complete at least one full year of ap-
proved postgraduate training before unrestricted licensure is granted. Unsupervised
moonlighting by residents holding a restricted (special) license is illegal and against
University policy. In addition, residents holding J-1 and H1-B visas are restricted from
moonlighting. Violators of this policy are subject to immediate dismissal and possible
prosecution by appropriate law enforcement agencies. It is also the responsibility of the
entity or institution hiring a resident to moonlight to determine whether unrestricted li-
censure is in place, whether adequate liability insurance is in place, and whether the
resident has the appropriate training and skills to carry out assigned duties

In promulgating this moonlighting policy, the University of Oklahoma School of Commu-
nity Medicine is not encouraging its residents to engage in moonlighting or professional
employment. The University accepts no responsibility for the financial consequences to
residents who engage in moonlighting if permission for that employment is withdrawn as
a consequence of poor performance in the training program or for other causes such as
work hour restrictions.

GMEC approved: 04-01-2009 Policy # 716
GMEC revision: 06-17-2010
GMEC Implemented: 08-01-2010
GMEC Responsibilities, Generally

The Graduate Medical Education Committee (GMEC) is responsible for the institutional oversight of residency training programs under guidelines established by the Accreditation Council for Graduate Medical Education (ACGME). The Committee works with College administration, program directors, and institutional liaisons to carry out its responsibilities.

The GMEC will establish and implement policies and procedures regarding the quality of education and the work environment for the residents in all programs.

GMEC Composition and Meetings:
1. Voting membership: DIO serves as chair, Associate DIO serves as vice chair, program director - or in program director’s absence an associate program director - from each ACGME approved residency, Chief Medical Officers of SFH, SJMC, and HMC, a resident, elected by peers, from each ACGME approved residency program, chair of Resident Executive Council, and OUCOM-T Associate Dean of Finance or their designee.
2. Non-voting membership: secretary of GMEC, GME Coordinator, and invited guests of DIO and/or GMEC.
3. Quorum: one more than half of members present
4. Agenda: The DIO or GMEC approves all items for GMEC agenda. Requests for agenda consideration must include a written statement of background and goals, as well as specific proposals and timelines, if appropriate. Reports and informational items will be distributed in advance of meetings.
5. Meetings: GMEC must meet at least six times per year and maintain written minutes.

GMEC Responsibilities: GMEC will assure that, at a minimum, the following requirements are met and that the institution is effective in supporting and promoting its sponsored residency training programs.

1. Stipends and position allocation:
   a. Annual review will occur and recommendations will be made to the Sponsoring Institution regarding resident stipends, benefits, and funding for resident positions.

2. Effective communication with program directors:
   a. Ensure that communication mechanisms exist between the GMEC and all program directors within the institution.
   b. Ensure that program directors maintain effective communication mechanisms with the site directors at each participating institution and site to maintain proper educational oversight at all sites.

3. Resident duty hours:
a. Develop and implement written policies and procedures regarding resident duty hours to ensure compliance with the Institutional, Common, and Program Specific Requirements of the ACGME.

b. Consider for approval requests from program directors prior to submission to an RRC for exceptions in the weekly limit on duty hours up to 10 percent or up to a maximum of 88 hours, in compliance with ACGME Policies and Procedures for duty hour exceptions.

4. Resident supervision:
   a. Monitor programs' supervision of residents and ensure that supervision is consistent with:
      i. Provision of safe and effective patient care;
      ii. Educational needs of residents;
      iii. progressive responsibility appropriate to residents' level of education, competence, and experience; and
      iv. other applicable common and Program Specific Requirements.

5. Communication with medical staff:
   a. Communicate on a periodic basis with leadership of the medical staff regarding the safety and quality of patient care that includes:
      i. The annual report to the Organized Medical Staffs;
      ii. Description of resident participation in patient safety and quality of care education; and
      iii. The accreditation status of programs and any citations regarding patient care issues.

6. Curriculum and evaluation:
   a. Assure that each program provides a curriculum and an evaluation system that enables residents to demonstrate achievement of the ACGME general competencies as defined in the Common and Program Specific Requirements.

7. Resident status:
   a. Assure that programs select, evaluate, promote, transfer, discipline, and/or dismiss residents in compliance with the Institutional and Common Program Requirements.

8. Oversight of program accreditation:
   a. Review all ACGME program accreditation letters of notification and monitor action plans for correction of citations and areas of noncompliance.

9. Management of institutional accreditation:
   a. Review the Sponsoring Institution’s ACGME letter of notification from the Institutional Review Committee and monitor action plans for correction of citations and areas of noncompliance.

10. Oversight of program changes:
a. Review the following for approval prior to their submission by program directors to the ACGME:
   i. All applications for ACGME accreditation of new programs;
   ii. Changes in resident complement;
   iii. Major changes in program structure or length of training;
   iv. Additions and deletions of participating institutions;
   v. Appointments of new program directors;
   vi. Progress reports requested by any Review Committee;
   vii. Responses to all proposed adverse actions;
   viii. Requests for exceptions of resident duty hours;
   ix. Voluntary withdrawal of program accreditation;
   x. Appeals of an adverse action; and,
   xi. Appeal presentations to a Board of Appeal or the ACGME.

11. Experimentation and innovation:
   a. Provide effective oversight of all phases of educational experiments and innovations that may deviate from Institutional, Common, and Program Specific Requirements, including:
      i. Approval prior to submission to the ACGME and/or respective Review Committee;
      ii. Adherence to procedures for “Approving Proposals for Experimentation or Innovative Projects” in ACGME Policies and Procedures; and,
      iii. Monitoring quality of education provided to residents for the duration of such a project.

12. Oversight of reductions and closures:
   a. Oversee all processes related to reductions and/or closures of:
      i. Individual programs;
      ii. Major participating institutions; and,
      iii. The Sponsoring Institution.

13. Vendor interactions:
   a. Provide a statement or institutional policy (not necessarily GME-specific) that addresses interactions between vendor representatives/corporations and residents/GME programs.

GMEC approved: 4-1-2009 Policy # 721
Office of Resident & Student Affairs and
the Graduate Medical Education Committee

1. The Office of Resident and Student Affairs provides administrative support services for students and residents and acts in a liaison capacity between the administration of OU School of Community Medicine, affiliated teaching institutions, the residents and students.

2. The Resident Program Specialist is available to answer questions; complete forms; process applications; assist in obtaining special and full medical licensure; ECFMG, DEA and OBNDD certifications; assist with USMLE and COMLEX applications; coordinate the National Residency Matching Program (NRMP); and perform a variety of other tasks. The telephone number for this office is (918) 660-3505.

3. The Designated Institutional Official provides guidance to the resident, spouse, significant other and his or her family members, as well as consultation related to student teaching and evaluation strategies.

4. The small number of students and residents at OU School of Community Medicine permits close, personal attention not only in the teaching programs but also in the services provided to its resident physicians.

The Graduate Medical Education Committee is the designated College committee responsible for institutional oversight of residency training programs under guidelines established by the ACGME. Membership of the GMEC includes Program Directors, administrative representatives of the College and of the major teaching hospitals, and residents selected annually by their peers. The GMEC works with the College administration and all Program Directors to carry out its functions of institutional oversight and policy making.
**Resident Executive Council**

A representative and an alternate member should be elected by their peers in each program to serve on the Resident Executive Council. These two members serve as the spokesperson(s) for their department.

The meetings provide an open avenue of communication and are attended by the DIO, the Associate DIO, and Office of Resident and Student Affairs.

**Purposes of the Resident Executive Council:**

1. Its major purpose is to provide an effective forum for communication between residents, administration, and faculty.
2. To build interdepartmental relationships and collaboration among our residents.
3. All subjects of interest to the resident in any program are fair game for these meetings – no matter how big or small.
4. Is responsible for selecting the two resident members of each Internal Review Team.

To facilitate the widest possible communication to all residents, minutes of the meetings are recorded and placed on the OU Tulsa web page soon after each meeting. The Chair of the Council attends and becomes a full voting member of GMEC. The REC is responsible for selecting the two resident members of each Internal Review Team.
Administrative Support for Residents in the Event of Disaster

The University of Oklahoma School of Community Medicine is committed to assisting in reconstituting and restructuring residents' educational experiences as quickly as possible after a disaster that disrupts residency education in one or more residency programs.

Definition of Disaster

For the purposes of this policy, a disaster is an event or set of events that causes significant disruption or alteration to the residency training experience in one or more residency programs.

Declaration of a Disaster

When warranted, the Executive Dean of the School of Community Medicine or his designee will make a formal declaration of disaster. A notice of declaration will be made known as soon as possible and, depending on the size and extent of the disaster, will be published on the School of Community Medicine website, the University of Oklahoma website, and other appropriate and available media sources. Along with information relating to the disaster, there will be instructions regarding actions to be taken by individuals affected by the disaster including information on how residents, faculty, staff, and program directors are to contact College administration for further instruction.

Reporting of Disaster to the Accreditation Council for Graduate Medical Education

Within ten days after the declaration of a disaster, or sooner if possible, the Associate Dean for Graduate Medical Education (or another institutionally designated person if the institution determines that the Associate Dean is unavailable) will contact the ACGME to formally notify them of the disaster declaration and discuss the projected impact on resident education and preliminary response plans. The ACGME will work with the institution to establish reasonable due dates for the affected programs to (a) submit program reconfigurations to ACGME if necessary and (b) inform each program's residents of reconfigurations and resident transfer decisions that may be required to provide continuation of training. The due dates for submission shall be no later than 30 days after the disaster unless other due dates are approved by ACGME.
Resident Transfers and Program Reconfiguration

Insofar as the School of Community Medicine and its major affiliated institutions cannot provide at least an adequate educational experience for each of its residents/fellows because of a disaster, the College will work with program directors to (a) arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows, or (b) assist the residents in permanent transfers to other programs/institutions; i.e., enrolling in other ACGME-accredited programs in which they can continue their education.

If more than one program/institution is available for temporary or permanent transfer of a particular resident, the preferences of each transferring resident will be considered by the transferring program/institution. School of Community Medicine programs must make the keep/transfer decision expeditiously so as to maximize the likelihood that each resident will complete the resident year in a timely fashion.

At the outset of a temporary resident transfer, the residency program must inform each transferred resident of the minimum duration and the estimated actual duration of his/her temporary transfer and continue to keep each resident informed of such durations. If and when a program decides that a temporary transfer will continue to and/or through the end of a residency year, it must so inform each such transferred resident.

ACGME Responsibilities in the Event of a Disaster

1. On its website, ACGME will provide, and periodically update, information relating to the disaster.

2. On its website, ACGME will provide phone numbers and email addresses for emergency and other communication with ACGME from disaster affected institutions and programs. In general,
   • DIO can call or email the Institutional Review Committee Executive Director with information and/or requests for information.
   • Program Directors can call or email the appropriate Review Committee Executive Director with information and/or requests for information.
   • Residents can call or email the appropriate Review Committee Executive Director with information and/or requests for information.

3. On its website, ACGME will provide instructions for changing resident email information on the ACGME Web Accreditation Data System.

4. ACGME will establish a fast track process for reviewing and approving or not approving submissions from programs relating to program changes to address disaster effects, including, without limitation, (a) the addition or deletion of a participating institution (b) change in the format of the educational program, and (c) change in the approved resident complement.
Responsibilities of the ACGME and Institutions Offering to Accept Transferring Residents

Institutions offering to accept temporary or permanent transfers from programs affected by a disaster are required by the ACGME to complete a form found on the ACGME website. Upon request, the ACGME will provide necessary information to affected programs and residents. Subject to authorization by an offering institution, ACGME will post information from the form on its website. ACGME will also expedite the processing of requests for increases in resident complement from non-disaster affected programs to accommodate resident transfers from disaster affected programs. The RRCs will expeditiously review applications, make decisions, and communicate decisions to institutions offering to accept transferring residents.

GMEC approved: 4-1-2009 Policy # 726
Residency Closure/Reduction

1. Notification: When a decision has been made to close or reduce a residency program, the GMEC, DIO, all current residents in the program, and all accepted residents, if applicable, will be notified in writing of the closure or reduction.

2. Completion: Every effort will be made to allow current residents to complete their education.

3. Assistance to Transfer: If any current residents are unable to complete their education due to the closure or reduction, every effort will be made to assist those residents in identifying a program where they can continue their education.

4. Neither OUCOM-T nor its programs may require residents to sign a non-competition agreement.

GMEC approved: 4-1-2009 Policy # 710
Changes in Residency Program Structure, Size, and Development of New Program

All proposed changes to residency training programs (Accreditation Council for Graduate Medical Education {ACGME} accredited and non-accredited programs) are handled through the Graduate Medical Education Committee (GMEC) of the School of Community Medicine.

For ACGME accredited programs, the ACGME requires the GMEC to review and approve proposals prior to submission to the ACGME. In addition, all correspondence and applications to the ACGME must be co-signed by the DIO. For the College, the DIO is the Associate Dean for Academic Programs (refer to policy 719). This policy also applies to non-accredited programs (refer to policy 702).

Reasons for Program Changes

There are four major reasons that programs and departments may find it necessary or desirable to change. These include:

1. The need to increase or decrease the number of residents in a training program.
2. Changes in the number of required years of training within a discipline.
3. The decision to organize and apply for the development and accreditation of a new program.
4. The decision to voluntarily request withdrawal of an accredited residency program.
5. The decision to move the major site of training for a program.

Such changes frequently impact other training programs, patient care, and resources of the associated institution. Because of this, all potential changes must be considered in the light of how those changes can or will affect the institutions and departments involved. Coordination of resources and workforce is of the utmost importance and must be considered within the context of the ability of all involved institutions to meet their goals and responsibilities.

Procedure

1. Creation of a Proposal for Program Changes

A proposal must be sent to the Office of GME for review by the GMEC. Proposals should include the information noted below and be made available for review no later than three weeks prior to the meeting of the GMEC, generally monthly. A schedule of meeting times is available through the Office of GME. In addition, program directors
and/or chairmen should appear before the GMEC to briefly discuss the proposal. The presentation of the proposal should last no more than ten minutes. The program’s RRC should be contacted with regard to deadlines.

Information to be included in a proposal includes:

A. The explicit reason for proposed change.

B. How the proposed change could affect the educational mission of the program and department. For new programs and major changes, how the proposal addresses the strategic goals of the College. How changes will affect the growth and development of the affiliated institutions.

C. How accreditation requirements affect proposed changes. How the requirements will be assured. Proposals for new programs must indicate how critical accreditation requirements will be met.

D. How changes will be handled so as not to adversely affect clinical care or other training programs. Letters of support from chairmen, clinic managers, and/or program directors are an important part of the proposal.

E. The financial implications for the proposed changes. Indicate how the program intends to finance the new positions or programs.

2. Review by the GMEC

Once the proposal has been presented to GMEC, the GMEC may question the presenter on the content noted above. The role of the GMEC is to assure that the proposal is educationally sound, meets the requirements of accrediting bodies, and meets the strategic goals of the College. The GMEC has the following options or actions available:

A. Approve the proposal if the GMEC determines that the proposal is sound and is in the best interest of the institution.

B. Table the proposal and ask for additional information.

C. Reject the proposal if it is not educationally sound or is not in the best interests of or has the likelihood of adversely impacting the College and its affiliated institutions.

GMEC approved: 4-1-2009 Policy # 711
Administrative Academic Actions

Administrative academic actions include, but are not limited to, oral reminders, written notification and plan of corrective action, suspension, and termination from the residency program. The particular administrative action imposed shall be based on individual circumstances and will not necessarily follow the sequential order in which they are described below. In the event a resident is subject to any administrative action beyond an oral reminder, the resident shall be provided a written statement of these actions by the Program Director.

Note: When actions beyond oral reminders occur, the University may be required to disclose or report the matter to affiliated institutions, medical licensing agencies, and credentialing bodies, especially if sanctions and/or practice restrictions are involved.

A. Oral Reminder

This is a discussion between the Program Director and a resident concerning a minor or isolated performance deficiency. The objective is to correct the deficiency through a collegial discussion concerning how the resident’s performance falls short of what is expected and provide an explanation of what must be done to correct the deficiency.

B. Written Notification and Plan of Corrective Action

If the use of an oral reminder has not corrected the performance deficiency, such a reminder is impractical or inappropriate for the level of attention required, or if the deficiency is no longer an isolated matter, a written notification of the deficiency and plan of correction is warranted. This formalizes, via a written notification, the discussion between the program director and the resident concerning the performance deficiency. It also outlines a plan of corrective action, describes further monitoring and evaluation, and specifies any required practice restrictions. Such requirements may be beyond the usual program requirements.

1. Significant deficiencies may include but are not limited to any of the following:
   a) Failure to meet performance standards set by the training program.
   b) Misconduct that infringes on the principles and guidelines set forth by the training program.
   c) Documented and recurrent failure to complete medical records in a timely and appropriate manner.
   d) Failure to meet the requirement to inform the Program Director of any professional employment outside the residency program or to comply with limitations established.
   e) Reasonably documented professional misconduct or ethical charges brought against a resident, which bear on his/her fitness to participate in the training program or patient care.
   f) Failure to comply with University’s compliance program, University policy,
or the provision of safe and effective patient care.

g) Failure to participate in required institutional risk management training, health screening, and OSHA training.

2. When a resident is provided a written notification of deficiency, the notification should clearly describe both the performance deficiency and the standards used to define the deficiency, and set forth a clear set of expectations for future performance. A specific plan of corrective action shall be established by the Program Director. This notification and plan of correction should be provided to the resident in a timely manner, usually within one week of the deficiency being investigated and confirmed.

3. The written notification will also establish a reasonable length of time in which the resident must correct the deficiency and clearly identify any practice restrictions required during that period.

4. A copy of the notification will be provided to the Designated Institutional Official.

5. Depending on compliance with the corrective action established by the Program Director, a resident may be:
   a) reinstated to the program without further corrective action,
   b) continued on a plan of corrective action with or without restrictions,
   c) placed on suspension, or,
   d) terminated from the residency program.

C. Suspension

1. A resident may be suspended from a residency program for reasons including, but not limited to, any of the following:
   a) Failure to meet the requirements of a written notification and plan of corrective action.
   b) Any of the reasons listed in paragraphs 1a-1g of section B.
   c) The resident is deemed an immediate danger to patients, himself or herself, or to others—pending further investigation.
   d) Failure to comply with the medical licensure laws of the State of Oklahoma—pending further investigation or appeal.
   e) Failure to maintain required professional liability coverage as stipulated in the eligibility requirements of the College—pending further investigation or appeal.
   f) Failure to pass required medical licensing exams and/or obtain required licensure.
   g) Evaluation for disruptive behavior, alcohol, or substance abuse.

2. When a resident is suspended, a written notice of the suspension, the reasons for the action, and the period of suspension shall be provided to the resident by the Program Director with a copy of the notice forwarded to the Designated Institutional Official.

3. Suspension may be with or without pay depending upon the circumstances.

4. Suspension must be followed by appropriate measures determined by the Program Director to assure satisfactory resolution of the problem(s). During this time, the resident will be placed on "administrative leave" and may not participate
in regular duties, rounds, or educational conferences.

5. Subsequent to a period of suspension a resident may be:
   a) reinstated without further corrective action,
   b) reinstated on a plan of corrective action with or without restrictions,
   c) continued for an additional period on suspension, or,
   d) terminated from the residency program.

6. Periods of suspension are appropriately and reasonably limited in time depending upon the reason(s) for the suspension.

D. Termination

1. Termination from a residency program may occur for reasons including but not limited to any of the following:
   a) Failure to meet the requirements of a written notification and plan of corrective action.
   b) Failure to fully comply with the terms and conditions of suspension.
   c) Any of the reasons listed in paragraphs 1a-1g of section B.
   d) Illegal conduct.
   e) Failure to comply with the medical licensure laws of the State of Oklahoma.
   f) Failure to maintain required professional liability coverage as stipulated in the eligibility requirements of the College.
   g) Failure to pass required medical licensing exams and/or obtain required licensure.
   h) Participating in any type of moonlighting activities without the knowledge and prior written approval of the Program Director.
   i) Failure to continue in a Physician Recovery Program as a part of an ongoing treatment plan.

2. At the time of notification to the resident, the Program Director shall provide the resident a written letter of termination stating the reasons for such action and the date the termination becomes effective. A copy of this notice shall be forwarded to the Designated Institutional Official.
Grievances

The University, through its designated officials, retains the right to make final determination as to the academic qualifications, performance evaluations, professional conduct, promotion, suitability for continued training, and certification of resident physicians participating in the University's graduate medical education programs. This section defines the policies and procedures for resident grievances if a dispute arises.

A. Definition of a Grievance

1. An allegation of wrongful academic or other disciplinary action (e.g. failure of the Program Director to follow established policy or procedures) that has resulted in or could result in dismissal, non-renewal of a residency agreement, non-promotion to the next level of training, or other actions that could significantly threaten a resident’s intended career development and resulting in restriction of residency activity, failure to promote, suspension, or termination of residency training.

2. A formal request for adjudication of an unresolved complaint concerning work environment or issue related to the residency program and/or faculty, but specifically excluding complaints of discrimination, harassment of a sexual, racial, or other nature, or appropriate accommodation for disability that is investigated and addressed through University Equal Employment Opportunity policy and procedure.

3. Actions, including termination of residency training, resulting from a resident's failure to comply with the requirements of the medical licensure laws of the State of Oklahoma are not subject to the grievance procedure(s).

4. Actions, including termination of residency training, resulting from a resident's repeated failure to pass or failure to be eligible to take all of the requisite examinations for licensure to practice medicine in the United States are not subject to the grievance procedure(s).

5. Actions including termination of residency training resulting from a resident’s inability to maintain required professional liability insurance are not subject to the grievance procedure.

B. Grievance Procedure

1. Residents who exercise their right to use this procedure agree to accept its conditions as outlined.

2. A resident may have a grievance only on the matters stated in Section A.1, and A.2 above.

3. The resident shall first discuss his/her grievance with the training Program Director and attempt to resolve the issue within the program. In order to pursue the right to file a grievance, this must occur within seven (7) working days of the date on which the resident was notified by the Program Director of the action in question.

4. If the resident is unable to resolve the matter at the level of the Program Director and intends a formal grievance hearing, he/she must request a meeting with the Designated Institutional Official for the purpose of discussing his/her griev-
ance. In order to pursue the right to file a grievance, this request must be in writing and must contain the specific grounds for filing the grievance. The request must be submitted within seven (7) working days of the failed attempt to resolve the issue with the Program Director.

5. The Designated Institutional Official shall meet with the resident to discuss his/her grievance.

6. The Designated Institutional Official shall attempt to resolve the grievance between the parties involved. Both parties will be notified in writing by the Designated Institutional Official of the resolution, or if he determines that the matter cannot be resolved.

7. Within seven (7) working days of notification of the resident by the Designated Institutional Official that the matter cannot be resolved, the resident may request a grievance hearing by a Resident Appeals Committee. The request for a hearing shall be written and submitted to the Dean of the School of Community Medicine. If no appeal is filed within the seven (7) working day period, the case is considered closed.

8. Upon receipt of a properly submitted request for a hearing, the Dean of the College of Medicine-Tulsa shall appoint an ad hoc Resident Appeals Committee for the purpose of considering the specific grievance(s) of the resident physician.

9. The Resident Appeals Committee shall be composed of six (6) members: three (3) selected from the faculty of the School of Community Medicine clinical departments and three (3) selected from residents within programs in the School of Community Medicine, other than the program in which the complainant is a resident. The Chair of the Appeals Committee shall be selected by the Dean from the faculty members appointed and is a voting member. The Designated Institutional Official, or his/her designee, shall serve ex officio, without vote, on the Appeals Committee. The parties shall be notified of the membership of the Committee. Committee members with a conflict of interest will be replaced.

10. The Chair of the Appeals Committee or the Designated Institutional Official shall notify the parties of the date, time, and location of the hearing. Parties are responsible for (1) giving such notice to any witnesses whom they wish to call for testimony relevant to the matters in the grievance, and (2) arranging for participation of witnesses in the hearing. The hearing shall be scheduled to ensure reasonably that the complainant, respondent, and essential witnesses are able to participate.

11. The resident may be advised by legal counsel at his/her own expense. If the resident intends to have legal counsel present at the hearing, the resident must notify the Designated Institutional Official in writing at least fifteen (15) working days prior to the Appeals Committee hearing. Legal counsel for the complainant and the respondent may advise their clients at the hearing but may not directly address the Appeals Committee or witnesses. Legal Counsel for the University may advise the Appeals Committee at the request of the Chair or the Designated Institutional Official.

12. If the resident is accompanied by legal counsel at the hearing or, if permitted by the Designated Institutional Official for GME at any prior steps where the resi-
dent and University official(s) meet, University legal counsel shall also be present.

13. The parties shall each submit a list of the witnesses to be called and the actual exhibits to be presented at the hearing to the Designated Institutional Official at least seven (7) working days in advance of the hearing. The parties are responsible for acquiring evidence and requesting witnesses' attendance. The list of witnesses and copies of exhibits from each party will be provided to the other party and to the Appeals Committee Chair. In the event either party objects to the listed witnesses or exhibits, it shall make such objection to the Appeals Committee Chair in writing at least 3 working days prior to the hearing. The Chair shall make a determination regarding any objections and shall notify the parties prior to the hearing.

14. In the event the grievance is resolved to the satisfaction of all parties prior to the hearing, a written statement shall indicate the agreement that has been reached by the parties and shall be signed and dated by each party and by the Chair of the Appeals Committee. This agreement shall be filed with the Dean of the School of Community Medicine. A copy of the final decision shall also be forwarded to the Designated Institutional Official for the administrative file maintained in the Office of Resident & Student Affairs.

15. The Resident Appeals Committee shall hear the grievance. The Committee shall determine the procedure and conduct of the hearing. The hearing shall be closed unless all principals in the case agree to an open hearing. The Designated Institutional Official shall arrange audio tape recording of the hearing and copies will be provided to the parties upon request.

16. The Appeals Committee shall render a signed, written report of its findings and recommendations regarding the dispute in question to the Dean of the School of Community Medicine. The Committee’s report shall be prepared and properly transmitted within seven (7) working days after conclusion of its deliberations.

17. The Dean of the School of Community Medicine shall review the findings and recommendations of the Appeals Committee and render a final decision regarding the grievance and appropriate action. Within fifteen (15) working days of receipt of the Appeals Committee's findings and recommendations, the Dean
shall inform the resident and the Program Director of the findings of the Appeals Committee and of the Dean's decision. A copy of the Dean's decision shall be transmitted to the Chair of the Appeals Committee and to the Designated Institutional Official to be placed in the resident's administrative file maintained in the Office of Resident & Student Affairs.
Medical Examiner Cases

There is often confusion as to which deaths come under the purview of the medical examiner. State law (63 Okla.Stat. §938) is quite specific and requires that the medical examiner be notified of deaths in the following categories:

1. Violent deaths, whether apparently homicidal, suicidal, or accidental, including but not limited to, deaths due to thermal, chemical, electrical, or radiational injury, and deaths due to criminal abortion, whether apparently self-induced or not;
2. Deaths under suspicious, unusual or unnatural means;
3. Deaths related to disease which might constitute a threat to public health;
4. Deaths unattended by a licensed medical or osteopathic physician for a fatal or potentially-fatal illness;
5. Deaths of persons after unexplained coma;
6. Deaths that are medically unexpected and that occur in the course of a therapeutic procedure;
7. Deaths of any inmates occurring in any place of penal incarceration; and
8. Deaths of persons whose bodies are to be cremated, buried at sea, transported out of state, or otherwise made ultimately unavailable for pathological study.

Unattended by licensed physician
The individual must have been under care for a fatal or potentially fatal illness. Deaths in this category are usually:

1. Persons found dead without obvious cause;
2. Unattended at any time by a licensed physician;
3. Unattended by a physician during terminal illness that appears unrelated to previous diagnoses;
4. Sudden death, when in apparent good health;
5. After rapidly fatal, unexplained illness;
6. Fetal death attended by a midwife.

Cases constituting a possible hazard to the public health often fall into these categories.

It is emphasized that a nonviolent death within 24 hours after hospital admission is not necessarily a medical examiner case. Patients dying shortly after entering emergency rooms are not necessarily medical examiner cases. If the probable cause of death can be ascertained from the history and physical examination, and if the cause of death can be said to be natural, a medical examiner's investigation is unnecessary.

All deaths following injury must be reported to the medical examiner regardless of the interval between injury and death, if the injury is in any way related to the death.
Visiting Resident

It is recognized that an educational program may benefit from including residents from another institution for rotations in the program. Therefore, residents from other programs approved by The ACGME or the AOA may participate in visiting rotations at The University of Oklahoma School of Community Medicine – Tulsa (OUCM-T) in accordance with the policies outlined below.

II. Residents applying for visiting rotations will receive a packet of information to assist them in completing the application process. The following documentation must be received before approval may be granted and approval is required prior to scheduling in departments:

A. A letter from the Resident’s Program Director attesting to the Resident’s good standing in that program and endorsing the request to participate in the OUCM-T rotation.

B. Proof of appropriate medical licensure (defined as a valid S.M.D., M.D., or D.O. license); Bureau of Narcotics and Dangerous Drugs (BNDD) and Drug Enforcement Administration (DEA) registration; and current Advanced Cardiac Life Support (ACLS) certification or Pediatric Advanced Life Support Certification (PALS) if applying for a pediatric rotation. The preferred form of proof is a notarized copy of the license, the BNDD and DEA registration cards, and the ACLS/PALS certification cards.

C. Proof of adequate professional liability insurance coverage (defined as a minimum of $1,000,000/$1,000,000 “occurrence” type only) for the dates of the rotation. Preferred proof is certification by the insurance carrier. Minimum information required in a certification includes the name and address of the carrier, the dates of coverage, policy type, and policy limits.

D. Proof of current TB skin test with negative result valid for the dates of the rotation. Proof of additional immunizations may be required.

E. Proof of completion of the OUCM-T HIPAA Privacy Training.

F. Signed OUCM-T Confidentiality Agreement.

II. All materials should be returned to the Resident Program Coordinator-Resident and Student Affairs Department at least 30 days before the requested start date of the rotation. Upon receipt of all materials, the OUCM-T DIO will render a decision and respond, in writing or e-mail notification, to both the Resident and her/his Program Director, copying the Resident Program Coordinator.

Before a visiting resident may begin a rotation, the OU COM-Tulsa program director
accepting the visitor must approve a written educational plan with competency-based goals and objectives, educational methods including required clinical experiences and reading assignments, and the evaluation tools that the program and/or instructor will use to assess the resident’s competence. If the course is not part of an established OU residency program’s curriculum, the course instructor must approve the education plan. A copy of the resident’s final performance evaluation must be on file with the OU COM-Tulsa in the office of Resident and Student Affairs.

III. Copies (or the originals) of all correspondence and documentation related to must be forwarded to and maintained by the Office of Resident and Student Affairs

IV. An annual processing fee of $150.00 must be submitted with the application. The application will not be processed until the fee is received.

GMEC approved: 11-20-2008 Policy # 712
Effective date: July 1, 2009
Application Form for Visiting Resident

PLEASE PRINT OR TYPE

NAME: __________________________________________________________

Last/First/Middle

ADDRESS: _________________________________________________________

Street/City/State/Zip

TELEPHONE: Day __________________ Evening ______________________

EMAIL: _________________________________________________________

MEDICAL SCHOOL: ____________________________ School Degree Year

RESIDENCY TRAINING: ____________________________________________

Institution Specialty Year

WHAT OUCM-T PROGRAM DO YOU WISH TO VISIT? ____________________

NAME OF ATTENDING PHYSICIAN: _________________________________

DATES OF ROTATION: From ________________ To _________________

YOUR SIGNATURE: ______________________________ DATE: ____________

Return form and documentation to Resident & Student Affairs.

APPROVED: ______________________________ DATE: ______________

DIO

OU School of Community Medicine-Tulsa

GMEC approved: 4-1-2009 Policy # 713
Please find a complete posting of all updated and relevant general University policies: [http://hr.ou.edu/policies/default.asp](http://hr.ou.edu/policies/default.asp). Some of the policies are included in the resident handbook for your reference.

### 5.18 POLICY ON PREVENTION OF ALCOHOL ABUSE AND DRUG USE ON CAMPUS AND IN THE WORKPLACE

The University of Oklahoma recognizes its responsibility as an educational and public service institution to promote a healthy and productive environment. This responsibility demands implementation of programs and services facilitating that effort. The university is committed to a program to prevent the abuse of alcohol and the illegal use of drugs and alcohol by its students and employees. The university program includes this policy, which prohibits illegal use of drugs and alcohol in the workplace, on university property or as part of any university-sponsored activities. In order to meet these responsibilities, university policy:

1. Requires all students and employees to abide by the terms of this policy as a condition of initial and continued enrollment/employment.

2. Recognizes that the illegal use of drugs and alcohol is in direct violation of local, state and federal laws as well as university policies included in this policy, the Staff and Faculty Handbooks, and the Student Code of Responsibility and Conduct. University policy strictly prohibits the illegal use, possession, manufacture, dispensing or distribution of alcohol, drugs or controlled substances in the workplace; on its premises; or as a part of any university-sponsored activities.

3. Considers a violation of this policy to be a major offense, which can result in a requirement for satisfactory participation in a drug or alcohol rehabilitation program, referral for criminal prosecution, and/or immediate disciplinary action up to and including termination from employment and suspension or expulsion from the university. A criminal conviction is not required for sanctions to be imposed upon an employee or student for violations of this policy.

4. Recognizes that violations of applicable local, state and federal laws may subject a student or employee to a variety of legal sanctions including but not limited to fines, incarceration, imprisonment and/or community service requirements. Convictions become a part of an individual's criminal record and may prohibit certain career and professional opportunities. A current listing of applicable local, state and federal sanctions can be obtained through the Office of Student Affairs and Human Resources.

5. Requires an employee to notify his/her supervisor in writing of a criminal conviction for drug or alcohol-related offenses occurring in the workplace no later than five calendar days following the conviction.

6. Provides access to the university's Employee Assistance Programs and Student Counseling Services for counseling and training programs that inform students and employees about the dangers of drug and alcohol abuse. Voluntary participation in or referral to these services is strictly confidential.

7. Forbids an employee from performing sensitive safety functions while a prohibited drug is in his/her system.

8. Mandates drug testing of sensitive safety employees prior to employment,
when there is reasonable cause, after an accident, on a random basis, and before returning to duty after refusing to take a drug test or after not passing a drug test. (Sensitive safety employees are defined in CFR Volume 32, Part 280 and CFR Volume 49, Part 653. This legislation is available for review in Human Resources.)

9. Provides for annual distribution of this policy to all staff, faculty and students.

Health risks generally associated with alcohol and drug abuse can result in but are not limited to a lowered immune system, damage to critical nerve cells, physical dependency, lung damage, heart problems, liver disease, physical and mental depression, increased infection, irreversible memory loss, personality changes and thought disorders.

The university's Employee Assistance Programs and Student Counseling Services staff are responsible for informing students and employees about the dangers of drug and alcohol abuse and the availability of counseling and rehabilitation programs. The appropriate provost or executive officer is responsible for notifying federal funding agencies within 10 calendar days whenever an employee is convicted of a drug-related crime that occurred in the workplace. This policy is based on the Drug Free Workplace Act of 1988 (P.L.100-690, Title V, Subtitle D) and the Drug Free Schools and Communities Act Amendments of 1989 (P.L.101-226) and is subject to the grievance procedure as stated in the Staff and Faculty Handbooks and the university discipline system as outlined in the Student Code of Responsibility and Conduct.
5.19 RACIAL AND ETHNIC HARASSMENT POLICY (revised 9-27-95) - Introduction

- Diversity is one of the strengths of our society as well as one of the hallmarks of a great university. The University of Oklahoma supports diversity and therefore is committed to maintaining employment and educational settings which are multicultural, multiethnic and multiracial. Respecting cultural differences and promoting dignity among all members of the University community are responsibilities each of us must share.

Racial and ethnic harassment is a growing concern across American college campuses. It has taken various forms, from criminal acts (assault and battery, vandalism, destruction of property) to anonymous, malicious intimidation, most often directed toward persons whose race or ethnicity is readily identifiable. In employment, racial/ethnic harassment is race discrimination which interferes with an employee’s ability to perform his or her duties or creates a hostile or intimidating work environment, prohibited by law under Title VII of the Civil Rights Act of 1964. In the educational context, racial/ethnic harassment is race discrimination which interferes with students’ opportunities to enjoy the educational program offered by the University, prohibited by law under Title VI of the Civil Rights Act of 1964.

Policy Statement - principles of academic freedom and freedom of expression require tolerance of the expression of ideas and opinions which may be offensive to some, and the University respects and upholds these principles. The University also adheres to the laws prohibiting discrimination in employment and education. The University recognizes that conduct which constitutes racial/ethnic harassment in employment or educational programs and activities shall be prohibited and is subject to remedial or corrective action as set forth in this policy. This policy is premised on the University’s obligation to provide a nondiscriminatory environment which is conducive to employment and learning. The University will vigorously exercise its authority to protect employees and students from harassment by agents or employees of the University, students, and visitors or guests. Specifically,

1. Agents or employees of the University, acting within the scope of their official duties, shall not treat an individual differently on the basis of race, color, or national origin in the context of an employment or educational program or activity without a legitimate nondiscriminatory reason, so as to interfere with or limit the ability of the individual to participate in or benefit from the services, activities or privileges provided by the University; and,

2. The University shall not subject an individual to different treatment on the basis of race by effectively causing, encouraging, accepting, tolerating or failing to correct a racially hostile environment of which it has notice.

Remedies or Corrective Actions - Violation of this policy shall result in corrective action(ies) or remedy(ies) designed to reestablish an employment or educational environment which is conducive to work or learning. Corrective actions or remedies will include disciplinary action directed by the executive officer having responsibility for the offender, where appropriate. Remedies or corrective actions will be tailored to redress the specific problem and may range from apologies, mandatory attendance at specific training programs, reprimands, suspension, demotion, to expulsion or termination. Remedies or corrective actions shall be based upon the facts and circumstances of each case and shall be in accordance with the terms and guidelines of the applicable campus grievance procedures.

Violations of this policy by students will be considered as violations of the Student Code and subject student offenders to the remedy(ies) and corrective action(s) provided by the Code.
Administrative Action - The University recognizes its obligation to address incidents of racial/ethnic harassment on campus when it becomes aware of their existence even if no complaints are filed, therefore, the University reserves the right to take appropriate action unilaterally under this policy.

With respect to students, the Vice President for Student Affairs/Vice Provost for Educational Services or other appropriate persons in authority may take immediate administrative or disciplinary action which is deemed necessary for the welfare or safety of the University Community. Any student so affected must be granted due process including a proper hearing. Any hearing involving disciplinary suspension or expulsion shall be conducted by a campus disciplinary council in accordance with Title 13, Section 1.2. of the Student Code. Lesser administrative or disciplinary action may be appealed to the Vice President for Student Affairs/Vice Provost for Educational Services. Such requests must be in writing and filed within seven calendar days following the summary action. The Vice President for Student Affairs/Vice Provost for Educational Services will issue a written determination to the student within three working days following the date the request is received.

With respect to employees, upon a determination at any stage in the investigation or grievance procedure that the continued performance of either party's regular duties or University responsibilities would be inappropriate, the proper executive officer may suspend or reassign said duties or responsibilities or place the individual on leave of absence pending the completion of the investigation or grievance procedure.

Retaliation - Threats or other forms of intimidation or retaliation against complaining witnesses, other witnesses, any reviewing officer, or any review panel shall constitute a separate violation of this policy which may be subject to direct administrative action.

Complaint Process - The complaint procedures delineated herein applies to all students, faculty, staff, guests or visitors. Complaints alleging violation of the racial and ethnic harassment policy will be reviewed and investigated by the appropriate University office. Complaints may be resolved informally or may proceed through the applicable formal complaint proceedings. Complaints may be filed in the following manner:

1. Complaints against students or student organizations shall be filed with the Equal Opportunity and Affirmative Action Office (EO/AAO) for review and investigation. The EO/AAO, or its designee, may assist in the informal resolution of the complaint or in processing a complaint through the applicable campus procedures.

2. Complaints against faculty or staff shall be filed with the Equal Opportunity and Affirmative Action Office. The EO/AAO or its designee may assist in the informal resolution of the complaint or in processing a complaint through the applicable campus procedures for faculty and staff.

3. Complaints against contractors working on university premises shall be filed with the Equal Opportunity and Affirmative Action Office. The EO/AAO or its designee may assist in the informal resolution of the complaint or in processing a complaint through the applicable campus procedures for faculty and staff.

4. Complaints against visitors or guests should be directed to the University police office on the campus where the incident occurred. The campus police will forward informational copies of all reports and inquiries dealing with discrimination, harassment or hate crimes to the EO/AAO.

Responsible Official - The Equal Opportunity and Affirmative Action Officer is charged with the responsibility for administering this policy. The Equal Opportunity and Affirmative Action Office will serve as a repository for all records of complaints, investigative reports, and remedies/corrective actions in connection with this policy. The Equal Op-
portunity and Affirmative Action Officer is the overall coordinator of all university activities dealing with discrimination in employment or education. To contact the University Equal Opportunity and Affirmative Action Office: Norman Campus, Room 102, Evans Hall, Ph: 325 - 3541, Health Sciences Center Campus, Room 113 Service Center, Ph: 271-2110.
The University of Oklahoma explicitly condemns sexual harassment of students, staff, and faculty. Sexual harassment is unlawful and may subject those who engage in it to University sanctions as well as civil and criminal penalties.

When criminal action is pursued in addition to an administrative grievance under this policy, the EO/AA Office will coordinate its investigative actions with the University or local law enforcement authorities to ensure that criminal prosecution is not jeopardized. The EO/AA Officer may defer administrative action at the request of University or local law enforcement, authorities pending completion of the criminal investigation. Where review by the EO/AA Officer or other university executive officer determines that immediate administrative action is necessary for the safety, health and well-being of the campus community, such action may be taken in advance of resolution of criminal charges.

Since some members of the University community hold positions of authority that may involve the legitimate exercise of power over others, it is their responsibility to be sensitive to that power. Faculty and supervisors in particular, in their relationships with students and subordinates, need to be aware of potential conflicts of interest and the possible compromise of their evaluative capacity. Because there is an inherent power difference in these relationships, the potential exists for the less powerful person to perceive a coercive element in suggestions regarding activities outside those appropriate to the professional relationship. It is the responsibility of faculty and staff to behave in such a manner that their words or actions cannot reasonably be perceived as sexually coercive, abusive, or exploitive. Sexual harassment also can involve relationships among equals as when repeated advances, demeaning verbal behavior, or offensive physical contact interfere with an individual's ability to work and study productively.

The University is committed to providing an environment of study and work free from sexual harassment and to insuring the accessibility of appropriate grievance procedures for addressing all complaints regarding sexual harassment. The University reserves the right, however, to deal administratively with sexual harassment issues whenever becoming aware of their existence. Records of all complaints, except for hearings before the Faculty Appeals Board, shall be transmitted to and maintained by the University Equal Opportunity and Affirmative Action Officer as confidential records.

The University encourages victims to report instances of sexual assault or other sex offenses, either forcible or nonforcible. In addition to internal grievance procedures, victims are encouraged to file complaints or reports with campus police or local law enforcement agencies by telephoning 911, as soon as possible after the offense occurs in order to preserve evidence necessary to the proof of criminal offenses. The campus police department is available to assist victims in filing reports with other area law enforcement agencies.

**Definition of Sexual Harassment** - Sexual harassment shall be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature in the following context: 1) when submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or academic standing, or 2) when submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individual, or 3) when such conduct has the purpose or effect of unreasonably interfering with an individual's work or academic performance or creating an intimidating, hostile, or offensive working or academic environment.

**Examples of Prohibited Conduct** - Conduct prohibited by this policy may include, but is not
limited to:

1) Unwelcome sexual flirtation; advances or propositions for sexual activity.
2) Continued or repeated verbal abuse of a sexual nature, such as suggestive comments and sexually explicit jokes.
3) Sexually degrading language to describe an individual.
4) Remarks of a sexual nature to describe a person’s body or clothing.
5) Display of sexually demeaning objects and pictures.
6) Offensive physical contact, such as unwelcome touching, pinching, brushing the body.
7) Coerced sexual intercourse.
8) Sexual assault.
9) Rape, date or acquaintance rape, or other sex offenses, forcible or non-forcible.
10) Actions indicating that benefits will be gained or lost based on response to sexual advances.

Retaliation- Any attempt to penalize or retaliate against a person for filing a complaint or participating in the investigation of a complaint of sexual harassment will be treated as a separate and distinct violation of University policy.

Sanctions- Appropriate disciplinary action may include a range of actions up to and including dismissal and/or expulsion.

Complaint Procedure - Complaints alleging a violation of the Sexual Harassment/Sexual Assault Policy shall be handled in accordance with the Grievance Procedure For Complaints Based Upon Discrimination, Sexual Harassment, Sexual Assault, Consensual Sexual Relationships, Retaliation Or Racial and Ethnic Harassment. To contact the University Equal Opportunity and Affirmative Action Office: Norman Campus, Room 102, Evans Hall, Ph: 325-3541, Health Sciences Center Campus, Room 113 Service Center, Ph: 271-2110.
5.20 CONSENSUAL SEXUAL RELATIONSHIPS POLICY - Rationale -

The University's educational mission is promoted by professionalism in faculty-student relationships. Professionalism is fostered by an atmosphere of mutual trust and respect. Actions of faculty members and students that harm this atmosphere undermine professionalism and hinder fulfillment of the University's educational mission. Trust and respect are diminished when those in positions of authority abuse, or appear to abuse, their power. Those who abuse, or appear to abuse, their power in such a context violate their duty to the University community.

Faculty members exercise power over students, whether in giving them praise or criticism, evaluating them, making recommendations for their further studies or their future employment, or conferring any other benefits on them. Amorous relationships between faculty members and students are wrong when the faculty member has professional responsibility for the student. Such situations greatly increase the chances that the faculty member will abuse his or her power and sexually exploit the student. Voluntary consent by the student in such a relationship is suspect, given the fundamentally asymmetric nature of the relationship. Moreover, other students and faculty may be affected by such unprofessional behavior because it places the faculty member in a position to favor or advance one student's interest at the expense of others and implicitly makes obtaining benefits contingent on amorous or sexual favors. Therefore, the University will view it as unethical if faculty members engage in amorous relations with students enrolled in their classes or subject to their supervision, even when both parties appear to have consented to the relationship.

As with faculty, staff may also be in a position to exert authority and control over students. Staff, too, must be conscious of the potential for abuse of power inherent in their relationships with students. Students rely on staff for assistance and guidance in dealing with issues such as scheduling of classes, financial aid, tutoring, housing, meals, employment, educational programs, social activities, and many other aspects of University life. Those who deal with students are expected to provide them with support and positive reinforcement. Staff who would deal with students in a sexual manner abuse, or appear to abuse, their power and violate their duty to the University community.

Definitions - As used in this policy, the terms "faculty" or "faculty member" mean all those who teach at the University, and include graduate students with teaching responsibilities and other instructional personnel. The terms "staff" or "staff members" mean all employees who are not faculty, and include academic and non-academic administrators as well as supervisory personnel. The term "consensual sexual relationship" may include amorous or romantic relationships, and is intended to indicate conduct which goes beyond what a person of ordinary sensibilities would believe to be a collegial or professional relationship.

Policy
Faculty/Student Relationship Within the Instructional Context - It is considered a serious breach of professional ethics for a member of the faculty to initiate or acquiesce in a sexual relationship with a student who is enrolled in a course being taught by the faculty member or whose academic work (including work as a teaching assistant) is being supervised by the faculty member.

Faculty/Student Relationship Outside the Instructional Context - Sexual relationships between faculty members and students occurring outside the instructional context may lead to difficulties. Particularly when the faculty member and student are in the same academic unit or in units that are academically allied, relationships that the parties view as consensual may appear to others to be exploitative. Further, in such situations
the faculty member may face serious conflicts of interest and should be careful to distance himself or herself from any decisions that may reward or penalize the student involved. A faculty member who fails to withdraw from participation in activities or decisions that may reward or penalize a student with whom the faculty member has or has had an amorous relationship will be deemed to have violated his or her ethical obligation to the student, to other students, to colleagues, and to the University.

Staff/Student Relationships - Consensual sexual relationships between staff and students are prohibited in cases where the staff member has authority or control over the student. A staff member who fails to withdraw from participation in activities or decisions that may reward or penalize a student with whom the staff member has or has had an amorous relationship will be deemed to have violated his or her ethical obligation to the student, to other students, to colleagues, and to the University.

Complaint Procedure - Complaints alleging a violation of the Consensual Sexual Relationships Policy shall be handled in accordance with the Grievance Procedure For Complaints Based Upon Discrimination, Sexual Harassment, Sexual Assault, Consensual Sexual Relationships, Retaliation Or Racial and Ethnic Harassment. To contact the University Equal Opportunity and Affirmative Action Office: Norman Campus, Room 102, Evans Hall, Ph: 325 - 3541, Health Sciences Center Campus, Room 113 Service Center, Ph: 271-2110.
5.21 DISCRIMINATION POLICY (OTHER THAN SEXUAL OR RACIAL/ETHNIC HARASSMENT) (revised 1-14-97)

The University has a policy of internal adjudication in matters relating to alleged discrimination. Any faculty member, staff member, or student, including those on temporary or part-time status, who believes that he or she has been discriminated or retaliated against should file a complaint under the Grievance Procedure For Complaints Based Upon Discrimination, Sexual Harassment, Sexual Assault, Consensual Sexual Relationships, Retaliation or Racial and Ethnic Harassment. Any attempt to penalize or retaliate against a person for filing a complaint or participating in the investigation of a complaint of discrimination and/or harassment will be treated as a separate and distinct violation of University policy. To contact the University Equal Opportunity and Affirmative Action Office: Norman Campus, Room 102, Evans Hall, Ph: 325 - 3541, Health Sciences Center Campus, Room 113 Service Center, Ph: 271-2110.
5.22 REASONABLE ACCOMMODATION POLICY

The University of Oklahoma will reasonably accommodate otherwise qualified individu-
als with a disability unless such accommodation would pose an undue hardship, would
result in a fundamental alteration in the nature of the service, program or activity or in
undue financial or administrative burdens. The term "reasonable accommodation" is
used in its general sense in this policy to apply to employees, students and visitors.

Reasonable accommodation may include, but is not limited to: (1) making existing facili-
ties readily accessible and usable by individuals with disabilities, (2) job restructuring,
(3) part-time or modified work schedules, (4) reassignment to a vacant position if quali-
fied, (5) acquisition or modification of equipment or devices, (6) adjustment or modification
of examinations, training materials or policies, (7) providing qualified readers or
interpreters, (8) modifying policies, practices and procedures.

Reasonable accommodation with respect to employment matters should be coordinated
with Human Resources and the disabled individual. Reasonable accommodation with
respect to academic matters, including but not limited to faculty employment, should be
referred to the Office of the Provost while all other issues of reasonable accommodation
should be referred to the Office of the Vice President for Administrative Affairs.

Individuals who have complaints alleging discrimination based upon a disability may file
them with the university's affirmative action officer in accordance with prevailing univer-
sity discrimination grievance procedures.

5.24 Grievance Procedure FOR COMPLAINTS BASED UPON DISCRIMINATION,
SEXUAL HARASSMENT, SEXUAL ASSAULT, CONSENSUAL SEXUAL
RELATIONSHIPS, RETALIATION OR RACIAL AND ETHNIC HARASSMENT (REVISED
1-14-97)

WHO MAY USE PROCEDURE- THE GRIEVANCE PROCEDURE EMBODIED HEREIN
SHALL BE AVAILABLE TO ANY PERSON WHO, AT THE TIME OF THE ACTS
COMPLAINED OF, WAS EMPLOYED BY, WAS AN APPLICANT FOR EMPLOYMENT,
OR WAS ENROLLED AS A STUDENT AT THE UNIVERSITY OF OKLAHOMA.

Filing of Complaint- Persons who have complaints alleging discrimination based upon
race, color, national origin, sex, age 40 or above, religion, disability, status as a veteran
or complaints alleging sexual harassment, consensual sexual relationships, retaliation,
or racial and ethnic harassment shall file them in writing with the Equal Opportunity and
Affirmative Action Officer, hereafter referred to as EO/AA Officer, or with their depart-
ment head/chair, academic dean, campus judicial coordinator, Vice Provost for Educa-
tional Services, or administrative supervisor. These individuals and the EO/AA Officer or
the EO/AA Officer's designee are referred to as "Administrator."

Complainants who exercise their right to use this procedure agree to accept its condi-
tions as outlined. Where multiple issues exist, (i.e. sexual harassment and violation of
due process or grade appeal), the complainant must specify all of the grounds of the
grievance of which the complainant should have reasonably known at the time of filing.
A grievance filed under this procedure may normally not be filed under any other Uni-
versity grievance procedure. Depending on the nature of the issues involved, the com-
plainant will be advised by the EO/AA Officer or his/her designee about the appropriate
procedure(s) to utilize.

Timing of Complaint- Any complaint must be filed with the EO/AA Officer or other ap-
propriate administrator within 180 calendar days of the act of alleged discrimination or
harassment. All other time periods may be reasonably extended by the administrator.

Administrative Action- The University recognizes its obligation to address incidents of
discrimination and harassment on campus when it becomes aware of their existence even if no complaints are filed, therefore, the University reserves the right to take appropriate action unilaterally under this procedure.

**With respect to students**, the Vice President for Student Affairs/Vice Provost for Educational Services or other appropriate persons in authority may take immediate administrative or disciplinary action which is deemed necessary for the welfare or safety of the University Community. Any student so affected must be granted due process including a proper hearing. Any hearing involving disciplinary suspension or expulsion shall be conducted by a campus disciplinary council in accordance with Title 13, Section 1.2, of the Student Code. Lesser administrative or disciplinary action may be appealed to the Vice President for Student Affairs/Vice Provost for Educational Services. Such requests must be in writing and filed within seven calendar days following the summary action. The Vice President for Student Affairs/Vice Provost for Educational Services will issue a written determination to the student within three working days following the date the request is received.

**With respect to employees**, upon a determination at any stage in the investigation or grievance procedure that the continued performance of either party's regular duties or University responsibilities would be inappropriate, the proper executive officer may suspend or reassign said duties or responsibilities or place the individual on leave of absence pending the completion of the investigation or grievance procedure.

**Withdrawal of Complaint**- The complainant may withdraw the complaint at any point during the investigation or prior to the adjournment of a formal hearing.

**Confidentiality of Proceedings and Records**- Investigators and members of the Hearing Panel are individually charged to preserve confidentiality with respect to any matter investigated or heard. A breach of the duty to preserve confidentiality is considered a serious offense and will subject the offender to appropriate disciplinary action. Parties and witnesses are admonished to maintain confidentiality with regard to these proceedings.

All records, involving discrimination or harassment, upon disposition of a complaint, shall be transmitted to and maintained by the EO/AA Officer as confidential records except to the extent disclosure is required by law. This includes records of complaints handled by administrators.

**Proceedings**

1. **Investigation**- Upon receipt of a complaint, the EO/AA Officer or other appropriate administrator is empowered to investigate the charge, to interview the parties and others, and to gather any pertinent evidence. The investigation should be completed within 60 calendar days of receipt of the complaint, or as soon as practical. The investigator shall prepare a written record of the investigation.

In arriving at a determination of a policy violation, at any stage of the proceedings, the evidence as a whole and the totality of the circumstances and the context in which the alleged incident(s) occurred shall be considered. The determination will be made from the facts on a case by case basis. Upon completion of the investigation, the EO/AA Officer or other administrator is authorized to take the following actions:

   a) **Satisfactory Resolution**- Resolve the matter to the satisfaction of the University and both the complainant and the respondent. If a resolution satisfactory to the University and both parties is reached through the efforts of the EO/AA Officer or other administrator, the administrator shall prepare a written statement indicating the resolution. At that time the investigation and the record thereof shall be closed.
b) Dismissal- Find that no policy violation occurred and dismiss the complaint, giving written notice of said dismissal to each party involved. Within 15 calendar days of the date of the notice of dismissal, the complainant may appeal said dismissal in writing to the EO/AA Officer by requesting a hearing according to the provisions of the section entitled “Hearing.”. If no appeal is filed within the 15 calendar day period, the case is considered closed.

c) Determination of Impropriety- Make a finding of impropriety and notify the parties of the action to be taken. Either party has the right to appeal said determination in writing within 15 calendar days of the date of notice of determination to the EO/AA Officer by requesting a hearing according to the provisions of the section entitled “Hearing.”. If no appeal is filed within the 15 calendar day period, the case is considered closed.

In the case of a complaint against a faculty member, the administrative investigator may determine that the evidence is sufficiently clear and serious so as to warrant the immediate commencement of formal proceedings as provided in the Abrogation of Tenure, Dismissal Before Expiration of a Term Appointment, and Severe Sanctions section of the Faculty Handbook. If the President concurs with the administrator's finding, the case may be removed at the option of the accused from the grievance proceedings contained herein and further action in the case shall be governed by the Abrogation of Tenure, Dismissal Before Expiration of a Term Appointment, and Severe Sanctions section in the Faculty Handbook. Otherwise, this policy and procedure shall apply.

2. Hearing

a) Request for a Hearing - Appeals and complaints unresolved following an investigation may result in a hearing before a Hearing Panel selected from the membership of the Committee on Discrimination and Harassment as described below. For the Norman campus, faculty versus faculty grievances heard by the Faculty Appeals Board. The request for a hearing is to be addressed to the EO/AA Officer. The request for a hearing must contain the particular facts upon which the policy violation allegation is based as well as the identity of the appropriate respondent(s). A copy of the request shall be given to the proper respondent(s) by the EO/AA Officer. Written response to the request for a hearing must be sent to the EO/AA Officer within 10 calendar days of receiving notice that a hearing has been requested. A copy of the response shall be given to the party requesting the hearing.

b) Selection of a Hearing Panel- Within 10 calendar days following receipt of the written request for a hearing, the EO/AA Officer shall initiate the process to determine the members of the Hearing Panel who are to conduct a hearing. A five-member Hearing Panel will be selected by drawing from: on the Health Sciences Center, the twenty-four (24) member Committee on Discrimination and Harassment; and on the Norman Campus, from the sixteen (16) member Committee on Discrimination and Harassment and/or the fifty (50) member Faculty Appeals Board. In the case of faculty versus faculty complaints on the Norman Campus, the party requesting the hearing may request that the panel members be drawn only from the Faculty Appeals Board.

A Committee on Discrimination and Harassment shall be established on each campus and composed of: on the Health Sciences Center, eight (8) staff members, eight (8) students, and eight (8) faculty members; and on the Norman Campus, eight (8) staff members and eight (8) student members, with faculty representation being selected from the Faculty Appeals Board. On the Norman Campus, five (5) staff will be appointed by the Staff Senate and five (5) students will be appointed by UOSA; the President will appoint three (3) staff and three (3) students. At the Health Sciences Center, eight (8) faculty will be appointed by the Faculty Senate, eight (8) staff mem-
bers appointed by the Employee Liaison Council, and eight (8) students by the Student Government Association. The terms of appointment shall be for three (3) years with initial terms of 1, 2, and 3 years in each category to provide the staggered membership, except that each student shall be appointed for a one year term.

The EO/AA Officer or his/her designee shall preside at a drawing to determine the members of the Hearing Panel. The drawing shall be from the pool of names as outlined in the above paragraph. Names of persons shall first be removed from the pool who; (1) have direct involvement or knowledge of the incident involved; (2) are employed in the same budget unit; and (3) are related to either party in the grievance. The remaining names shall be placed in a container, and the drawing shall be made to determine the five members who are to serve on the Hearing Panel. Prospective panel members who have been determined by the drawing shall be asked to disqualify themselves should there be any possibility of their having a biased opinion concerning the grievance. For example, a close friend shall disqualify himself/herself. When, for any reasons, prospective panel members disqualify themselves, additional names shall be drawn from the container until a full panel is constituted. Either party to the complaint may ask the EO/AA Officer to disqualify any member of the Hearing Panel upon a showing of cause.

c.) Conference - Within 10 calendar days of receiving notification, or as soon as practical, the EO/AA Officer shall convene the Hearing Panel for an orientation conference and an informal discussion of the grievance. The panel will select a Chair of the Hearing Panel (hereafter referred to as the Chair) from the group of five Hearing Panel members. The EO/AA Officer shall be present during the informal discussion. At the beginning of the conference, the EO/AA Officer shall conduct an orientation for the panel members. Each panel member shall be given a copy of the written complaint, the request for a hearing, and the written response. No witnesses will be heard during the orientation conference. After the selection of a Chair and after the orientation is delivered to the panel members, the EO/AA Officer shall be excused. At that time the Hearing Panel will reach a decision as to whether there exist adequate grounds for a hearing. If the Panel decides at its pre-hearing conference that there is no basis for a hearing, it shall report the determination in writing to the proper executive officer with a copy to the President and the EO/AA Officer. The Executive Officer shall render his or her decision on the matter in writing to each of the parties involved in the informal proceedings.

d) Informal Hearing - In the event the Hearing Panel determines that there is a basis for a hearing, the Chair shall convene the panel for an informal hearing. Each panel member shall be given a copy of the Hearing Guidelines. The parties involved will be present at the informal hearing. No witnesses will be heard. The Chair of the Hearing Panel shall notify the parties of the date, time and location of the informal hearing. The hearing shall be scheduled to reasonably ensure that the complainant and respondent are able to participate. Upon request of the Chair, Legal Counsel may serve as an adviser to the Hearing Panel.

At all meetings, each party may be accompanied by an adviser. In the event that a party chooses to be advised by an attorney he/she may do so at his/her expense. If an adviser is used, the name of the person so assisting must be furnished to the Panel and the other party 10 calendar days in advance of the hearing conference. Advisers may advise their clients but may not directly address the Hearing Panel.

In the event the matter is resolved to the satisfaction of all parties prior to the formal hearing, a written statement shall indicate the agreement recommended by the parties and shall be signed and dated by each party and by the Chair. The recommendation will be referred to the appropriate Executive Officer for final determination.
In the event the panel by a majority vote decides at the informal hearing that there is no basis for a formal hearing, it may recommend that the grievance be dismissed. The panel shall report the recommendation in writing to the appropriate Executive Officer, with a copy to the President and the EO/AA Officer. The Executive Officer shall render his or her decision on the matter in writing to each of the parties involved in the informal hearing.

**e) Formal Hearing** - In the event that the panel determines the need for a formal hearing, The Chair will convene the panel and the parties for a formal hearing. The Hearing Panel procedures shall be established with reference to the Hearing Guidelines and shall provide that the parties may present all of the evidence that they consider germane to the determination. Further, the parties may call witnesses to testify and may cross-examine witnesses called by the other party. The hearing shall be closed unless all principals in the case agree to an open hearing. Audio tape recordings of the proceedings shall be arranged by the Chair and paid for by the University. Transcripts may be charged to the requesting party. In cases of alleged sexual assault on students, the accuser and the accused are entitled to the same opportunities to have others present during a campus disciplinary proceeding and both shall be informed of the outcome of the proceeding.

The Chair shall notify the parties of the date, time and location of the formal hearing. Parties are responsible for giving such notice to their witnesses. The hearing shall be scheduled to reasonably ensure that the complainant, respondent, and essential witnesses are able to participate.

In the event the matter is resolved to the satisfaction of all parties prior to completion of the formal hearing, a written statement shall indicate the agreement recommended by the parties and shall be signed and dated by each party and by the Chair. The recommendation will be referred to the appropriate Executive Officer for final determination.

**f) Panel’s Findings and Recommendations** - In the event that no solution satisfactory to the parties is reached prior to the completion of the formal hearing, the Panel shall make its findings and recommendations known to the proper executive officer, with copies to the President and the EO/AA Officer. The Panel’s report, with its findings and recommendations, shall be prepared and properly transmitted within seven (7) calendar days after conclusion of the formal hearing.

**g) Executive Officer’s Decision** - Within 15 calendar days of receipt of the Hearing Panel’s findings and recommendations, the proper executive officer shall inform the complainant and the respondent of the findings of the Hearing Panel and the officer’s decision. A copy of the officer’s decision shall be transmitted to the Chair of the Hearing Panel, with copies to the President and the EO/AA Officer. In a case investigated initially by an administrator, the administrator also shall be informed of the officer’s decision. In the event the allegations are not substantiated, reasonable steps in consultation with the accused may be taken to restore that person’s reputation.

**h) Appeal to the President** - The Executive Officer's decision may be appealed to the President within 15 calendar days of being notified of prospective action or of action taken, whichever is earlier. If the President does not act to change the decision of the Executive Officer within 15 calendar days of receiving the appeal, the decision of the Executive Officer shall become final under the executive authority of the President. To contact the Equal Opportunity and Affirmative Action Office: Norman Campus-Evans Hall, Room 102 or telephone (405) 325-3546; Health Sciences Campus-Services Center, Room 113 or telephone (405) 271-2110.
APPENDIX I

HOSPITAL MEDICAL DIRECTORS

The following is a list of hospital administrators who will have information regarding the rules and regulations of their respective institutions.

Saint Francis Hospital
6161 S. Yale Ave.
First Floor, Administration
Tulsa OK 74136-1992
494-1465

Peter A. Aran, M.D.
Chief Medical Officer

St. John Medical Center
1923 S. Utica Ave
Tulsa OK 74104-6520
744-2187

H. William Allred, Jr., M.D.
Vice President Medical Affairs and Director of Medical Education

Hillcrest Medical Center
1120 S. Utica Ave.
Tulsa OK 74104-0490
579-5230

Steven Landgarten, M.D.
Medical Director

Dept. of Veterans Affairs
Medical Center-Muskogee
Honor Heights Drive
Muskogee OK 74401-9917
1-918-577-3000

Karen Gribbin, M.D.
Chief of Staff

Laureate Psychiatric Clinic and Hospital
6655 S. Yale Ave.
Tulsa OK 74136-3329
481-4077

Jeffrey Mitchell, M.D.
Vice Pres./Medical Director

Shadow Mountain
Behavioral Health Systems
6262 S. Sheridan
Tulsa OK 74133
492-8200

Kevin Burgess
Chief Executive Officer

Oklahoma Forensic Hospital
P.O. Box 69
Vinita, OK 74301-0069
1-(918) 256-7841

William Burkett, LSLO, LSW,
Executive Director

Paul Lanier, M.D., Director of Clinical Services
Jane Phillips Episcopal Memorial Medical Center
3500 E. Frank Phillips Blvd.
Bartlesville OK 74006-2464
1-(918) 333-7200

David Stire
Chief Executive Officer

Tulsa VA Outpatient Clinic
9322 E. 41st St.
Tulsa OK 74145
628-2500

Karen Gribbin, M.D.
Chief Medical Officer

Claremore Comprehensive Indian Health Facility
101 S. Moore Ave.
Claremore OK 74017-5091
342-6200, ext. 434

Paul Mobley, D.O.
Clinical Director

W.W. Hastings Hospital
100 South Bliss
Tahlequah OK 74464-3345
1-(918) 458-3100

Douglas Nolan, M.D.
Clinical Director
APPENDIX II

TULSA MEDICAL EDUCATION FOUNDATION, INC.

The Tulsa Medical Education Foundation, Inc., established in June 1971, continues to support medical education in the Tulsa community. The consortium coordinates medical education programs between the community hospitals, residency programs, and the University of Oklahoma School of Community Medicine – Tulsa. The Foundation’s objective is to develop and support the residency programs, which in turn provide better patient care. As evidenced below, the members of the Board of Directors of major medical facilities in Tulsa are active participants.

BOARD OF DIRECTORS

Hospital Chief Executive Officers

Hillcrest Medical Center  Earl Denning
Saint Francis Hospital  Jake Henry
St. John Medical Center  David J. Pynn

Hospital Medical Directors

Hillcrest Medical Center  Steven Landgarten, M.D.
Saint Francis Hospital  David B. Thomas III, M.D.
St. John Medical Center  H. William Allred, Jr., M.D.

Hospital Chief Financial Officers

Hillcrest Medical Center  Robert Langland, CPA
Saint Francis Hospital  Barry Steichen, CPA, MBA
St. John Medical Center  Lex Anderson, CPA

University of Oklahoma School of Community Medicine – Tulsa

Gerard P. Clancy, M.D.  Dean & President of TMEF
Leeland N. Alexander  Senior Associate Dean
Ronald Saizow, M.D.  Designated Institutional Official

Community Physician Representative

Robert R. Bruce, M.D.
APPENDIX III

FACULTY AND STAFF

Office of the Dean 660-3095
Gerard P. Clancy, M.D., Dean
F. Daniel Duffy, M.D., Senior Associate Dean for Academic Program
Ronald B. Saizow, M.D., Assoc. Dean for Academic Program & Designated Institutional Official
Karen A. Mulkey, M.B.A., Community and Hospital Relations Officer

Office of Administration and Finance 660-3077
Leeland N. Alexander, Sr. Assoc. Dean for Admin. & Finance; Assoc. V. Pres. for Health Services
Jonathan E. Joiner, CPA, MBA, Asst. Dean for Finance; Director of Finance
Michelle McMillan, CPA, MBA, Executive Director of Finance & Administration
Cheryl A. Moseley, Assistant to Vice President

Office of Resident and Student Affairs 660-3505
Melissa J. Riley, GME Coordinator

OU Schusterman Library 660-3220
Stewart M. Brower, M.L.I.S., A.H.I.P., Library Director
Yolanda Sampson, Administrative Secretary

Operations 660-3555
Raymond A. List, Director of Operations
Angela M. Childers, Departmental Business Manager
Joe G. Kennedy, Associate Director of Operations for General Services
Joe H. Holderman, Assistant Director of Operations for Maintenance & Construction
Larry V. Reavis, Supervisor, Campus Security

Human Resources 660-3190
Barbara Abercrombie, Director of Human Resources
Melodie J. Frederick, Human Resource Analyst
V. Gail Roberts, Senior Human Resources Rep, (Benefits)
Kim Little, Senior Human Resources Rep.
Kevyn Bagby Grayson, Senior Administrative Assistant

Office of Clinical Affairs 660-3625
Robert J. Hudson, M.D., FAAP Medical Director for Clinical Services
Linda K. Smith, M.P.H., Director, Operations and Finance
Renee Engleking, RN, CCM, COHN-S, Director, Risk Management
Linda Carter, Director, Clinical Revenue
Sharon E. Allen, Administrative Assistant

Oklahoma Bioethics Center 660-3212
G. Kevin Donovan, M.D., Director
Mark D. Fox, M.D., Ph.D., M.P.H., Associate Director
Debi Garden, Staff Secretary

Medical Informatics
Richard M. Bryant, Jr., Ph.D., Director of Medical Informatics
Tammy Beagles, Project Manager

Information Technology 660-3540
Dana Saliba, Director
RESIDENCY PROGRAMS

Emergency Medicine  660-3823
Stephen Thomas, M.D., MPH, Professor, and Chair
Carolyn
Synovitz, M.D., Assoc. Professor, and Vice Chair
Boyd
Burns, D.O., Assistant Professor and Program Director
Wendy Palmer, Program Coordinator

Family Practice  619-4715
John W. Tipton, M.D., Associate Professor and Chair
Linda Oberst-Walsh, M.D., Clinical Assistant Professor and Program Director
Michael J. Sannito, Ph.D., M.A., L.P.C., L.M.F.T., Assist. Prof. and Assist. Program Director
Ginger Sutton, Program Coordinator
Anita Schell, Administrative Secretary

Family Practice/Psychiatry  660-3518
Ondria C. Gleason, M.D., Associate Professor and Psychiatry Chair
Bryan K. Touchet, M.D., Associate Professor and Program Director
Rhonda G. Wallace, Program Coordinator
Ginger Sutton, Program Coordinator

Family Practice – Rural, Ramona  536-2104
W. Michael Woods, M.D., Program Director
Sharon E. Tennant, Administrative Secretary

Internal Medicine  744-2548
Charles Foulks, M.D., Professor and Chair
Michael A. Weisz, M.D. FACP, Professor and Program Director
Erik A. Wallace, M.D., Assistant Professor and Associate Program Director
John M. Carment, M.D., Assistant Professor IM/Geriatrics and Associate Program Director
Barbara L. McCoy, Program Coordinator

Internal Medicine/Pediatrics  660-3395
Brian J. Yount, M.D., Assistant Professor of Internal Medicine & Pediatrics, Program Director
Douglas W. Stewart, D.O., Associate Professor of Pediatrics, Associate Program Director
Connie R. Trantham, Program Coordinator
Obstetrics & Gynecology 660-8359

Michael Gardner, M.D., MPH, Professor, and Chair
Nirupama DeSilva, M.D., Assistant Professor and Program Director
Melinda Hurst, Program Coordinator

Pediatrics 660-3416

G. Kevin Donovan, M.D., Professor and Interim Chair
Keith Mather, M.D., Assistant Professor and Program Director
Sarah Passmore, D.O., Assistant Professor and Associate Program Director
Renda Chubb, Program Coordinator

Psychiatry 660-3518

Ondria C. Gleason, M.D., Associate Professor and Chair
Bryan K. Touchet, M.D., Associate Professor and Program Director
Rhonda G. Wallace, Program Coordinator

Sports Medicine 619-4701

Lamont E. Cavanagh, M.D., Associate Professor and Fellowship Co-Director
T. Jeffrey Emel, M.D., Clinical Professor and Fellowship Co-Director
Eilene Pirtle, Fellowship Coordinator

Surgery 744-3908

C. Anthony Howard, M.D., Associate Professor and Interim Chair
Carmen Ruiz, M.D., Assistant Professor and Program Director
Gay Miller, Program Coordinator
THE UNIVERSITY OF OKLAHOMA CLINICS

Family Medicine Unit
Linda Oberst-Walsh, M.D., Medical Director
Charla Y. Rae, Department Business Manager

Internal Medicine Unit
William H. Yarborough, M.D., Associate Professor and Medical Director
Janice K. Guy, Senior Clinic Manager

Pediatrics Unit
William Geffen, M.D., Assistant Professor and Medical Director
Angela Catania, Clinic Administrator

Psychiatry Unit
Aaron Pierce, D.O. Assistant Professor and Medical Director
Louise Mathew, Clinic Manager

Surgery Unit
Carmen Ruiz, M.D. Assistant Professor and Medical Director
Gerald S. Bockmuller, Clinic Manager

Women’s Unit
Michael Gardner, M.D., Professor and Medical Director
Peggy Stilley, Clinic Manager

JUSTICE Center
Nichole Wallace, M.D., Faculty
Sarah Passmore, D.O., Faculty
Michael Baxter, D.O., Faculty
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