****

**FELLOWSHIP IN MINIMALLY INVASIVE GYNECOLOGIC SURGERY (FMIGS)**

6757 Katella Ave., Cypress, CA 90630‐5105 USA.

Ph: (800) 554‐2245 or (714) 503‐6200 • Fax: (714) 503‐6202

E‐mail: fmigs@aagl.org • Web Site: [www.aagl.org](http://www.aagl.org)

**NEW SITE APPLICATION**

All sections of the form applicable to the program must be completed in order to be accepted for review. The information provided should describe the proposed program. For items that do not apply, indicate N/A in the space provided. If any requested information is not available, an explanation should be provided in the appropriate place on the form.

Once the forms are complete, number the pages sequentially, including any appendices or attachments, in the bottom center. Send one complete copy electronically to the FMIGS administrative assistant at fmigs@aagl.org.

The FMIGS Board will only accept one final, completed application. Draft copies are not acceptable. If revisions are required after submission, you will be notified.

The fellowship director is responsible for the accuracy of the information supplied in this form. Incomplete applications, including incorrect or missing signatures, will be returned.

It is very important to review the program requirements prior to completing the application. The requirements may be downloaded from the Fellowship website ([www.fmigs.org](http://www.fmigs.org)).

Note that the process **can take months** from the time the application is received until it is evaluated by the FMIGS board.

**Fees**

The initial application should be submitted simultaneously with the application processing fee either by check or contacting the FMIGS administrative office for electronic submission.

A site visit fee will be applied once a site visit is scheduled.

An annual fee will be due and payable after notification that a site has been approved.

Include the following documents to the application:

References to the document entitled, “Requirements for a Post-Graduate Program in MIGS” are in brackets.

1. All Program Letters of Agreement (PLAs)
2. Policies and procedures for fellowship duty hours and work environment
3. Two-year curriculum and sample weekly block schedule
4. A blank copy of the forms that will be used including:
	1. Faculty Annual evaluation
	2. Program Evaluation
	3. Semiannual performance of the fellows
5. A blank copy of the final (summative) evaluation of fellows, documenting performance during the final period of education and verifying that the fellow has demonstrated sufficient competence to enter practice
6. Policy for supervision of fellows (addresses fellow responsibilities for patient care and progressive responsibility for patient management and faculty responsibilities for supervision)
7. A letter of support for fellow stipend and benefits
8. Copies of tools the program will use to provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice
9. Letters of support from (1) academic department chairperson or appropriate medical director and (2) obstetrics and gynecology residency director (in teaching hospital)
10. A copy of the contract between program and fellow that complies with the program requirements.
11. Application processing fee in the amount of $2,000.00 USD.

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| --- | --- |
| Program Name:  |       |

|  |  |
| --- | --- |
| Program Location:  |       |

|  |  |
| --- | --- |
| Program Director Name: |       |

|  |  |
| --- | --- |
| Desired Start Date: |       |

|  |  |
| --- | --- |
| Training Cycle: | [ ]  2-Year Program [ ]  3-Year Program |

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# Overall Goals

Please provide the overall goals of the fellowship program? (max 400 words)

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# Fellowship Training Program Description

Describe the 2-year/3-year fellowship training program, incorporating program requirements for a Post Graduate

Program in FMIGS and desired start date (if applicable)? (max 800 words)

|  |
| --- |
|       |

**Program Personnel and Resources**

1. Program Director Information

|  |  |
| --- | --- |
| Name:  |       |
| Title:  |       |
| Address:  |       |
| City, State, Zip code: |       |
| Country: |       |
| Telephone:  |       | Email: |       |
| AAGL Membership: | [ ]  Active  |
| Number of years teaching in this specialty: |       |

1. Associate Program Director (1) Information

|  |  |
| --- | --- |
| Name:  |       |
| Title:  |       |
| Address:  |       |
| City, State, Zip code: |       |
| Country: |       |
| Telephone:  |       | Email: |       |
| AAGL Membership: | [ ]  Active  |
| Number of years teaching in this specialty: |       |

1. Associate Program Director (2) Information – *Optional*

|  |  |
| --- | --- |
| Name:  |       |
| Title:  |       |
| Address:  |       |
| City, State, Zip code: |       |
| Country: |       |
| Telephone:  |       | Email: |       |
| AAGL Membership: | [ ]  Active  |
| Number of years teaching in this specialty: |       |

**Program Director Curriculum Vitae**

Using the form provided below, supply a one-page summary CV for the Fellowship Program Director. The statement “see CV” is not acceptable.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |       | MI: |       | Last Name: |       |
| Present Position: |       |
| Medical School Name: |       |
| Degree Awarded: |       | Year Completed: |       |
| Graduate Medical Education (residency and fellowships) with institution name and year of completion: |
| Residency Institution: |       | Year Completed: |       |
| Residency Institution: |       | Year Completed: |       |
| Fellowship Institution: |       | Year Completed: |       |
| Fellowship Institution: |       | Year Completed: |       |
| Certification and Re-Certification Information  | Current Licensure Data  |
| Specialty | Certification Year | Re-Certification Year | State | Date of Expiration (mm/yyyy) |
|       |       |       |       |       |
|       |       |       |       |       |
| Academic and Hospital Appointments - List the past ten years, beginning with your current position.  |
| Start Date (mm/yyyy) | End Date (mm/yyyy) | Description of Position(s) |
|       |       |       |
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|       |       |       |
| **Concise Summary of Role in Program:**       |
| **Reviewer for which journals:**      |
| **Selected Bibliography - Most representative Peer Reviewed Publications/Journal Articles from the last 5 years (limit of 10):**      |
| **Peer-reviewed research funding:**       |
| **Participation in Local, Regional, and National Activities/Presentations - Abstracts (Limit of 10 in the last 5 years):**      |
| **If not ABMS board certified, explain equivalent qualifications:**       |
|

|  |  |  |
| --- | --- | --- |
| Has your license to practice medicine ever been limited, suspended or revoked? | [ ]  YES | [ ]  NO |
| If yes, please explain: |       |
| Will you have 8 hours / week (average) protected to administrate the fellowship? | [ ]  YES | [ ]  NO |
| Will you directly supervise the fellow(s)? | [ ]  YES | [ ]  NO |
| Will you ensure that the fellow undertakes a research thesis by assigning a mentor? | [ ]  YES | [ ]  NO |
| Will you be free of any potential conflicts (e.g., concurrently serving as residency director) | [ ]  YES | [ ]  NO |

 |

**Associate Program Director (1) Curriculum Vitae**

Using the form provided below, supply a one-page summary CV for the Fellowship Associate Program Director. The statement “see CV” is not acceptable.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |       | MI: |       | Last Name: |       |
| Present Position: |       |
| Medical School Name: |       |
| Degree Awarded: |       | Year Completed: |       |
| Graduate Medical Education (residency and fellowships) with institution name and year of completion: |
| Residency Institution: |       | Year Completed: |       |
| Residency Institution: |       | Year Completed: |       |
| Fellowship Institution: |       | Year Completed: |       |
| Fellowship Institution: |       | Year Completed: |       |
| Certification and Re-Certification Information  | Current Licensure Data  |
| Specialty | Certification Year | Re-Certification Year | State | Date of Expiration (mm/yyyy) |
|       |       |       |       |       |
|       |       |       |       |       |
| Academic and Hospital Appointments - List the past ten years, beginning with your current position.  |
| Start Date (mm/yyyy) | End Date (mm/yyyy) | Description of Position(s) |
|       |       |       |
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|       |       |       |
| Concise Summary of Role in Program:      |
| Reviewer for which journals:      |
| Selected Bibliography - Most representative Peer Reviewed Publications/Journal Articles from the last 5 years (limit of 10):      |
| Peer-reviewed research funding:      |
| Participation in Local, Regional, and National Activities/Presentations - Abstracts (Limit of 10 in the last 5 years):      |
| If not ABMS board certified, explain equivalent qualifications:      |
| Will you be participating in the semi-annual evaluations [ ]  YES [ ]  NO |

**Associate Program Director (2) Curriculum Vitae**

Using the form provided below, supply a one-page summary CV for the Fellowship Associate Program Director. The statement “see CV” is not acceptable.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |       | MI: |       | Last Name: |       |
| Present Position: |       |
| Medical School Name: |       |
| Degree Awarded: |       | Year Completed: |       |
| Graduate Medical Education (residency and fellowships) with institution name and year of completion: |
| Residency Institution: |  | Year Completed: |       |
| Residency Institution: |  | Year Completed: |       |
| Fellowship Institution: |  | Year Completed: |       |
| Fellowship Institution: |  | Year Completed: |       |
| Certification and Re-Certification Information  | Current Licensure Data  |
| Specialty | Certification Year | Re-Certification Year | State | Date of Expiration (mm/yyyy) |
|       |       |       |       |       |
|       |       |       |       |       |
| Academic and Hospital Appointments - List the past ten years, beginning with your current position.  |
| Start Date (mm/yyyy) | End Date (mm/yyyy) | Description of Position(s) |
|       |       |       |
|       |       |       |
|       |       |       |
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|       |       |       |
| Concise Summary of Role in Program:      |
| Reviewer for which journals:      |
| Selected Bibliography - Most representative Peer Reviewed Publications/Journal Articles from the last 5 years (limit of 10):      |
| Peer-reviewed research funding:      |
| Participation in Local, Regional, and National Activities/Presentations - Abstracts (Limit of 10 in the last 5 years):      |
| If not ABMS board certified, explain equivalent qualifications:      |
| Will you be participating in the semi-annual evaluations [ ]  YES [ ]  NO |

 **Physician Faculty Roster**

List alphabetically and by site all physician faculty involved in fellow education. List no more than 10 faculty for each site.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Core FacultyY or N | Based Mainly at Site # | Specialty Field | Primary and SecondarySpecialties / Fields | No. of Years Teaching in This Specialty |
| Cert† (Y/N) | Original Cert Year | Cert Status | Re-cert Year |
|       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |
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† Certification for the primary specialty refers to ABMS Board Certification. Certification for the secondary specialty refers to sub-Board certification. If the secondary specialty is a core ACGME specialty (e.g., general surgery), the certification question refers to ABMS Board Certification. Include completion of FMIG column

Core Faculty Y=Yes / N=No

# Facilities

|  |
| --- |
| **SPONSORING INSTITUTION:** (The university, hospital, or foundation that has ultimate responsibility for this program.)  |
| Name of Sponsor:  |       |
| Address:  |       |
| City, State, Zip code:  |       |
| Country: |       |
| Type of Institution: (e.g., Teaching Hospital, General Hospital, Medical School)  |       |
| Name of Designated Institutional Official:  |       |
| Mailing Address: |       | Phone No.:  |       |
| City, State, Zip code: |       | Email:  |       |
| Name of Department Chairperson (if applicable) and contact information:       |
| Does SPONSOR have an affiliation with a medical school (could be the sponsoring institution)? | [ ]  YES [ ]  NO |
| If yes, name the medical school below and have an affiliation agreement that describes the effect of these arrangements on this program available.  |
| Name of Medical School:  |       |

|  |
| --- |
| **PRIMARY SITE (Site #1)** |
| Name: |       |
| Address: |       |
| City, State, Zip code: |       |
| Country: |       |
| Clinical Site?  | [ ]  YES [ ]  NO |
| Length of Fellow Rotations (in months) | Year 1: |       |
| Year 2: |       |
| Joint Commission Approved? [ ]  YES [ ]  NO  |
| If no, explain:       |

The Fellowship Director must submit any participating sites routinely providing an educational experience, required for all fellows, of one-month full time equivalent (FTE) or more. Duplicate as necessary.

|  |
| --- |
| **PARTICIPATING SITE (Site #2)** |
| Name: |       |
| Address: |       |
| City, State, Zip code: |       |
| Country: |       |
| Length of Fellow Rotations (in months) | Year 1: |       |
| Year 2: |       |
| Brief Educational Rationale: |       |
| PLA Between Program and Site:  | [ ]  YES [ ]  NO |
| If no, explain: |       |
| Joint Commission Approved? | [ ]  YES [ ]  NO |
| If no, explain: |       |

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| --- |
| **PARTICIPATING SITE (Site #3)** |
| Name: |       |
| Address: |       |
| City, State, Zip code: |       |
| Country: |       |
| Length of Fellow Rotations (in months) | Year 1: |       |
| Year 2: |       |
| Brief Educational Rationale: |       |
| PLA Between Program and Site:  | [ ]  YES [ ]  NO |
| If no, explain: |       |
| Joint Commission Approved? | [ ]  YES [ ]  NO |
| If no, explain: |       |

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| --- |
| **PARTICIPATING SITE (Site #4)** |
| Name: |       |
| Address: |       |
| City, State, Zip code: |       |
| Country: |       |
| Length of Fellow Rotations (in months) | Year 1: |       |
| Year 2: |       |
| Brief Educational Rationale: |       |
| PLA Between Program and Site:  | [ ]  YES [ ]  NO |
| If no, explain: |       |
| Joint Commission Approved? | [ ]  YES [ ]  NO |
| If no, explain: |       |

#  Surgical Profile of Program

Please enter the annual number of procedures performed at each institution (both inpatient and outpatient) that would be accessible to the fellow i.e. undertaken with oversight by fellowship faculty, including those procedures where faculty is available as needed. This number should NOT reflect all cases performed at the site if fellows cannot be involved.

|  | **Site #1** | **Site #2** | **Site #3** | **Site #4** | **Total** |
| --- | --- | --- | --- | --- | --- |
| 1. Hospital-Based Hysteroscopic myomectomy
 |       |       |       |       |  |
| 1. Office-Based Hysteroscopic myomectomy
 |       |       |       |       |  |
| 1. Hospital-Based Hysteroscopic Polypectomy, Lysis of adhesions or septoplasty
 |       |       |       |       |  |
| 1. Office-Based Hysteroscopic Polypectomy, Lysis of adhesions or septoplasty
 |       |       |       |       |  |
| 1. Laparoscopic hysterectomy +/- BSO
 |       |       |       |       |  |
| 1. Laparoscopic myomectomy
 |       |       |       |       |  |
| 1. Laparoscopic adnexal surgery
 |       |       |       |       |  |
| 1. Laparoscopic retroperitoneal dissection including Ureterolysis
 |       |       |       |       |  |
| 1. Laparoscopic management of Stage III / IV endometriosis
 |       |       |       |       |  |
| 1. Pelvic floor reconstructive procedures
 |       |       |       |       |  |
| 1. Cystoscopy (diagnostic and/or operative)
 |       |       |       |       |  |
| 1. Vaginal hysterectomy
 |       |       |       |       |  |
| 1. vNotes
 |       |       |       |       |  |
| 1. Vaginal septoplasty
 |       |       |       |       |  |

Please describe the proportion of laparoscopic procedures listed above that are performed using **robotic assistance** for each site (max 200 words).

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|        |

Please describe the depth and breadth of surgical experiences available to the fellows (max 400 words).

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|       |

**Program Resources**

Briefly describe the educational, clinical and simulation resources available for fellow education. The answer must include how specialty specific reference materials are accessible. It should also include resources provided by the program and the institution such as basic and translational science courses and optional advanced degrees (and, if so, is tuition covered) (max 400 words).

|  |
| --- |
|        |

Briefly describe how the fellow will conduct at least one IRB approved (if applicable) research project under the guidance of a faculty who can mentor them in basic science or clinical research relevant to minimally invasive gynecology. This project must be an original data-driven project, meta-analysis or a systematic review that conforms to PRISMA guidelines. Writing a textbook chapter, clinical opinion review article, or production of an educational video does not meet criteria for an approved research project. (max 400 words)

|  |
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|       |

 Is there a lactation room with refrigerator in proximity to the clinical responsibilities?

|  |
| --- |
|       |

# Rotation Objectives

What are the objectives of each rotation of the fellowship program (max 400 words)?

|  |
| --- |
|       |

# Fellow Appointments

Match with one fellow every other year – Position per year: 1

Match with one fellow every year – Position per year: 2

Match with two fellows every other year – Position per year: 2

|  |  |
| --- | --- |
| **Positions per year** |       |

1. Will there be other physicians being trained (such as residents or fellows from other specialties, subspecialty fellows, nurse practitioners, PhD or MD students) in the program, sharing educational or clinical experiences with the fellows? If yes, describe the impact those other learners will have on the program’s fellows (max 200 words).

|  |
| --- |
|       |

1. Describe how the program will handle complaints or concerns raised by the fellow(s). The answer must describe the mechanism by which individual fellows can address concerns in a confidential and protected manner as well as steps taken to minimize fear of intimidation or retaliation (max 200 words).

|  |
| --- |
|        |

# Evaluation (Fellows, Faculty, Program)

1. Will fellows be evaluated on their performance following each learning experience? [ ]  YES [ ]  NO

If no, explain If so comment on format

|  |
| --- |
|       |

1. Will these evaluations be documented (in written or electronic format)? [ ]  YES [ ]  NO

If no, explain

|  |
| --- |
|       |

1. Will the Fellowship director should evaluate fellow competencies at least every 6 months, meet directly with the fellow to give feedback and assess progress and goals, document and submit evaluation as part of the Annual Report? [ ]  YES [ ]  NO

If no, explain

|  |
| --- |
|       |

1. Will the Fellowship perform a summative evaluation on each fellow at the completion of the fellowship? [ ]  YES [ ]  NO

This may replace the final semiannual evaluation. The evaluation must:

1. Document the fellow’s performance during the final period of education
2. Verify that the fellow has demonstrated sufficient competence to practice without direct supervision

If no, explain

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1. Using the table below (add rows as needed), provide the methods of evaluation used for assessing fellow competence.

| **Competency** | **Assessment Method(s) and Evaluator(s)** |
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| Patient Care |       |
|       |       |
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|       |       |
| Medical Knowledge |       |
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|       |       |
| Practice-based learning & Improvement |       |
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| Interpersonal & Communication Skills |       |
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| Professionalism |       |
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| Systems-based Practice |       |
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1. Describe how fellows will be informed of the performance criteria on which they will be evaluated (max 200 words).

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1. Describe the system that ensures that faculty will complete written evaluations of fellows in a timely manner following each rotation or educational experience (max 200 words).

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1. Describe the system that fellows will use to provide annual confidential written evaluations of the teaching faculty. The answer must include evaluations at least once per year, the steps taken to maintain confidentiality, and the process by which evaluations are sought (max 200 words).

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1. Describe the system that the fellows will use to provide evaluation and feedback to the program at least annually (max 200 words).

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1. Describe the plan to hold an (at least) annual meeting to discuss the educational and research mentoring effectiveness of the program as well as the curriculum attended by Fellowship Director, program faculty, and at least one fellow. The discussion of the issues must be documented, and the results must be used to improve the program (Max 400 words).

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# Duty Hours and Conditions of Work

1. Briefly describe how the fellowship director and faculty evaluate the fellow’s abilities to determine progressive authority and responsibility, conditional independence and a supervisory role in patient care. Specify the criteria, and how the process differs by year of training (max 200 words).

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1. Will the fellows have attending privileges? [ ]  YES [ ]  NO
2. Are fellows permitted to moonlight? [ ]  YES [ ]  NO
3. Excluding call from home, what is the projected average number of hours on duty per week per fellow, inclusive of all in-house call and all moonlighting?

If the duty hour requirements (>80 hrs/wk) have been exceeded or might be exceeded, please provide an example of the circumstances (max 200 words).

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1. On average over a 4-week period, will fellows have 1 full day out of 7 free from responsibilities? [ ]  YES [ ]  NO
2. What is the projected LONGEST CONTINUOUS duty shift (in hours) worked by any fellow?
3. Please confirm that your fellow will be provided a stipend and benefits at the minimum equivalent to a PGY-5 or -6 house staff officer in the geographic region of the program. Please confirm that candidates invited for an interview will be informed, in writing or by electronic means, of the terms, conditions, and benefits of their appointment, including stipend and other financial support; vacations; parental, sick and other leaves of absence. Please confirm that candidates will receive a copy of their contract (and document this with each candidate individually). [ ]  YES [ ]  NO

If no, explain

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1. Please confirm the presence of the below required benefits:
2. The fellowship must provide fellows with health, disability and professional liability coverage at all sites and all pertinent information regarding this coverage. Liability coverage must include legal defense and protection against awards from claims reported or filed after the completion of the program(s) if the alleged acts or omissions of the fellows are within the scope of the program(s). Specify if liability coverage is provided for external rotations/electives. Research associated costs (IRB, equipment, publication) must be covered. [ ]  YES [ ]  NO

If no, explain

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1. Please confirm that candidates invited for an interview will be informed, in writing or by electronic means whether the following benefits are provided:
2. Travel to the annual meeting of the AAGL and bootcamp
3. Certification as console surgeon for Roboticrobotically-assisted laparoscopy

[ ]  YES [ ]  NO

If no, explain

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1. It is the expectation that programs will not require their fellows to sign a non-compete agreement or restrictive covenant. If the program does require this, they must notify both the FMIGS Board and notify in writing all applicants before an initial interview is scheduled. [ ]  Agree [ ]  Disagree

If you Disagree, explain

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# Fellows’ Scholarly Activities

Describe how will the program offer fellows the opportunity to participate in scholarly activities (max 200 words)?

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# Surgical Competence

1. Describe the process by which fellows will become involved in the management of patients requiring surgery, including the preoperative encounter, the performance of the surgical procedure, and the postoperative care of the patient. Discuss their level of participation/responsibility in the decision to perform a procedure, the selection of procedure, and the informed consent/patient counseling (max 200 words).

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1. Describe how in addition to the number of cases performed, the program will ensure the surgical competence of the fellows in the categories listed on the fellow case logs (max 200 words).

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1. Will fellows have the opportunity to perform cases as teaching assistants to other trainees (max 200 words)?

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# Medical Knowledge

**Regularly Scheduled Educational Sessions**

1. List all regularly scheduled educational activities of this program, including teaching rounds, clinical case conferences, gynecologic pathology conferences, interdepartmental conferences, specialty conferences, seminars, and other functions held primarily for the benefit of your fellows. Designate whether the activity is required (R), optional (O), or required of fellows only when they are on that particular service (RS). List them in the order of R, then RS, then O.

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| **Name of Activity** | **R/O/RS** | **Frequency Per Month** |
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1. How is individual fellow attendance tracked and remediated if necessary (max 100 words)?

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**ANTI-HARASSMENT POLICY**

The Fellowship does not tolerate harassment of its employees, members, or visitors and is committed to providing workplace, educational, and social events that are free of harassment based on race, color, national origin, sexual orientation, religion, age, sex, physical or mental disability, marital status, pregnancy, veteran status, or any other classification protected by law. You must review and comply with the policy is available on the Fellowship webpage.

**REPRESENTATIONS AND WARRANTIES**

By applying for a FMIGS program both the fellowship director and institution represent and warrant that each of the following statements is true and correct:

1. The fellowship director will maintain membership in the AAGL throughout the duration of the fellowship.
2. All submitted information in this application is true and complete to the best of our knowledge and belief.
3. We have received, read and will comply in full with the document entitled, “Program Requirements for Fellowships in Minimally Invasive Gynecologic Surgery”.
4. We agree to abide by such FMIGS guidelines, policies, procedures, rules, and regulations as may from time to time be adopted.
5. The institution and the fellowship director both understand and agree that the FMIGS Board may not accept or approve an application in its sole discretion, the reasons for which may not be disclosed or justified to the applicant.
6. We agree to practice medicine according to all professional and ethical standards applicable to specialty and country of clinical practice.
7. We shall produce adequate information for proper evaluation of the fellowship director’s and faculty professional competence, character, ethics and other qualifications, and for resolving any issues relating to such qualifications. We fully understand that any misstatements or omissions from this application are cause for denial of accreditation.
8. The fellowship director and sponsoring institution have the primary responsibility for the fellow’s training.

**FELLOWSHIP ACKNOWLEDGEMENTS AND RESPONSIBILITIES**

1. The FMIGS Board’s responsibilities include only the following:
	1. Establishing requirements for a fellowship program.
	2. Providing evaluation of Fellowship sites.
	3. Approval or disapproval of fellowship directors for training.
	4. Providing continuous evaluation of the program and director, which will be evaluated not only by the credentials of the fellow accepted for training, but also upon the skill, knowledge and experience obtained by the Fellow during training.
	5. Providing application forms for fellow and Program.
	6. Providing, as needed, advice and direction to potential or approved Fellows or fellowship directors and/or institutions.
	7. Providing a certificate to fellow upon completion of his/her training, if approved by the fellowship director and the FMIGS Board.
2. All details of the fellowship are subject to agreement between Fellowship Director and Fellow. The FMIGS Board disclaims all responsibilities except those specified in the immediately preceding paragraph.
3. In the performance and discharge of its obligations, and any provision of medical care, pursuant to this Agreement the institution and fellowship director are at all times acting independently of FMIGS and AAGL. Fellowship Director shall employ his/her own means and methods and exercise his/her own professional judgment in the performance of such services, and the FMIGS Board shall have no right of control or direction with respect to any such means, methods, or judgments, or with respect to any of the details of such services. The sole concern of the FMIGS Board under this Agreement or otherwise is that, irrespective of the means selected, such services shall be provided in a competent, efficient, and satisfactory manner. It is expressly agreed that the institution and fellowship director shall not for any purpose be deemed to be an employee, agent, partner, joint venture, ostensible or apparent agent, servant, or borrowed servant of the Fellowship.

# INSTITUTION AGREEMENTS AND RESPONSIBILITIES

1. If accepted as a FMIGS site, the institution agrees that the Fellowship Board may terminate the continued participation as a Fellowship site with or without prior notice if any of the objectives and terms of the Fellowship are not being achieved or followed.
2. Institution agrees not to accept any Fellow who has not successfully completed an approved ACGME OB/GYN residency program or equivalent approved by the FMIGS Board and/or who does not have a current license (provisional or otherwise) to practice medicine in the appropriate state and country.
3. As a FMIGS site, the institution accepts and assumes the responsibility for the training of the Fellow. As an approved FMIGS site, the institution hereby agrees to indemnify both of the AAGL and FMIGS, and to hold each of them harmless from and against any claims brought against each or both of them in connection with the Fellowship. The Fellowship will not be involved in or bear any responsibilities for any claims that might be made as a direct result of patient care rendered by fellowship director and/or the fellow and the institution, or disputes between or among the institution or department, the fellowship director or faculty, and the fellow.
4. As a FMIGS site, the institution reserves the right to terminate a fellowship appointment at any time. However, the institution/program must provide to the Fellowship Board, in writing, the reason(s) of the termination.
5. As a FMIGS site, the institution understands and agrees that the fellow will be required to complete a written evaluation regarding his/her training experience and that this information will be submitted to the Fellowship Board to be used at its discretion.
6. The institution understands and agrees that as a FMIGS site has guidelines with respect to the duties, responsibilities, liability insurance, and compensation of the fellow.
7. The institution ultimately is responsible for agrees to be responsible for the fellow’s training.
8. The institution acknowledges and agrees to maintain workplace standards described in the AAGL Anti-Harassment and Grievances Policies, available on the FMIGS website.

**FELLOWSHIP DIRECTOR’S ACKNOWLEDGEMENTS AND RESPONSIBILITIES**

1. Once accepted as a fellowship director, I agree that the Fellowship Board may discontinue my status as a fellowship director if any of the objectives and terms of the Fellowship are not being achieved or followed.
2. I agree not to enroll any fellow who has not successfully completed an approved ACGME OB/GYN residency program or equivalent approved by the FMIGS Board and/or who does not have a current license (provisional or otherwise) to practice medicine in the state and country unless approved by the FMIGS board.
3. I accept the responsibility for the training of the fellow and care of patients involved with the training.
4. I further acknowledge that fellowship training will culminate in issuance of a certificate of completion, if determined that the fellow’s performance has been satisfactory.
5. I further acknowledge that neither the AAGL nor FMIGS will be involved in or bear any responsibilities for any claims that might be made as a direct result of patient care rendered by the institution, faculty or fellow, or disputes between or among the institution and/or the faculty and/or the fellow.
6. I understand and agree that the fellow will be required to complete an evaluation regarding his/her training experience and that this information will be submitted to the Fellowship Board to be used at its discretion.
7. I understand and agree that it is my duty as fellowship director to make contractual arrangements with the fellow as specified in the program requirements.

# CONSENT TO RELEASE OF INFORMATION

By applying for appointment to become a fellowship director, I hereby:

1. Signify my willingness to appear for interviews regarding my application;
2. Authorize the FMIGS Board to consult with administrators, employees, and members of medical staffs of hospitals, medical schools, or organizations with which I have been associated with respect to my professional competence, character, and ethical qualifications;
3. Consent to the FMIGS Board’s inspection of all records and documents, including, but not limited to, medical records at hospitals, which may be material to an evaluation of my professional competence and my professional and ethical qualifications for the FMIGS. If medical records are reviewed, the identity of the patients will be kept Confidential;
4. Consent to the release of information concerning me by hospitals, medical schools, and organizations that is requested by the FMIGS Board to provide information relevant to the evaluation of my application to become a fellowship director.

**RELEASE OF LIABILITY**

By applying for appointment (or reappointment) both fellowship director and institution, hereby:

1. Release from liability AAGL and the FMIGS Board, and their employees, agents, and representatives, for any and all claims of any kind, character or nature arising in connection or resulting from their professional review and all related actions with respect to the evaluation of the applicant Institution or fellowship director’s qualifications and appointment to become a fellowship institution or fellowship director;
2. Release from liability all individuals and organizations who provide to the FMIGS Board and its individual members, AAGL and their representatives, information regarding my professional competence, ethics, character, and other qualifications for an appointment as fellowship director; and

 AGREE TO INDEMNIFY AND HOLD HARMLESS THE FELLOWSHIP BOARD, ITS INDIVIDUAL MEMBERS, AGENTS, EMPLOYEES, REPRESENTATIVES, AND ASSIGNS, FROM ANY AND ALL LIABILITY FOR DAMAGES OF ANY KIND OR CONSEQUENCES ARISING FROM , RELATING TO, OR INCURRED WITH RESPECT TO, (1) THE ACTS OF THE FELLOWSHIP DIRECTOR OR THE FELLOW DURING THE COURSE OF THE FELLOWSHIP IN MINIMALLY INVASIVE GYNECOLOGIC SURGERY, INCLUDING, WITHOUT LIMITATION, LIABILITY FOR INJURIES TO PATIENTS RESULTING FROM TREATMENT PROVIDED BY FELLOWSHIP DIRECTOR OR FELLOW, AND/OR (2) PERFORMANCE OF THE RESPONSIBILITIES OF FELLOWSHIP DIRECTOR OR FELLOW PURSUANT TO THIS APPLICATION AND AGREEMENT.

**FELLOWSHIP DIRECTOR AND INSTITUTION AGREEMENT**

We have read, understand and agree to comply in full with the following documents (available at [www.fmigs.org](http://www.fmigs.org)) and sections:

1. Requirements for a Postgraduate Program in Minimally Invasive Gynecologic Surgery.
2. Fellowship Anti-Harassment Policy.
3. Fellowship Grievance Policy.
4. Sections of this document:
5. Representations and Warranties
6. Fellowship Acknowledgments and Responsibilities
7. Institution Agreements and Responsibilities
8. Fellowship Director’s Acknowledgements and Responsibilities
9. Consent to Release of Information
10. Release of Liability

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| *[Institution name]* |

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| Program Director Name: |       |  |  |
| Signature: |  | Date: |       |
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| Associate Program Director (1) Name: |       |  |  |
| Signature: |  | Date: |       |
| Associate Program Director (2) Name: |       |  |  |
| Signature: |  | Date: |       |
| Designated Institutional Official Name: |       |  |  |
| Signature: |  | Date: |       |
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