



**American Osteopathic Colleges of Ophthalmology and Otolaryngology-
Head and Neck Surgery**

Otolaryngology/FPS Program Director's Annual Report of the Program

Please return this completed form to:

Ralph McClish • AOCCO-HNS 3200 Carlisle Blvd NE, Suite 225 Albuquerque, NM 87110 • (855) 262-6646 • ralph@monstully.com

Program Name: _____ Specialty: _____
 Program Director: _____ Director of Medical Education: _____
 Review Period: _____ OPTI Academic Officer: _____

Instructions:

To monitor the progress of otolaryngology/facial plastic surgery residency training programs, the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery (AOCCO-HNS) requires all program directors to complete an annual evaluation report of the program. Please submit the report within thirty (30) days of completion of the academic year. Failure to submit the report may affect the program's accreditation status.

Program Director Responsibilities			If a "NO" is indicated, an explanation is required
1. The Quarterly and Annual Evaluations of the Residents are completed by the program director.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
2. The program director provides oversight of the residents' scholarly activity.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
3. There is a process to evaluate and monitor quality of teaching faculty.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
4. Does the program follow/implement the model curriculum?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
5. Program complies with all the patient care and educational course requirements.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
6. Program complies with the outside rotation standard.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
7. Date last ACA Program Director Workshop attended:			
8. Date last Faculty Development Program attended:			

Board Pass Rates	In-Service Exam Scores
a. # Graduates Eligible _____. b. # who sat for Boards ____; # who passed ____ c. Status of those who failed:	Total mean raw score for program and nation for the past three years: 2017 ____ Program ____ Nation 2016 ____ Program ____ Nation 2015 ____ Program ____ Nation
Fill Rate	Segregated Totals
a. I filled ____% of my approved/authorized/funded training slots last July. b. Total number of filled positions ____ c. Total number of approved positions ____	Average cumulative amount of procedures completed by the residents for the last three years ____ 2017 ____ 2016 ____ 2015

Program Director Evaluation of Residents			<i>If a "NO" is indicated, an explanation is required</i>
1. The institution and program fulfilled all of its responsibilities to the residents.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
2. All unfulfilled responsibilities to the residents have been addressed.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
3. The residents' academic projects (research, scientific paper, statistics course or poster for credit) were reviewed and approved.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
4. Residents participated in the annual inservice examination.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
5. The inservice examination results were discussed with the residents.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
6. Residents have established the required panel of patients in the ambulatory setting and have followed patients throughout the academic year.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
7. Did any residents require special counselling for deficiencies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
8. Were resident counselling sessions documented?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
9. Program complies with all patient care and educational course requirements.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Program Director comments in any other areas not specifically mentioned above.

I certify that the information on this form is correct and accurate.

Signature of Program Director	
Date	

I certify that the information on this form is correct and accurate.

Signature of DME or OPTI Academic Officer	
Date	

Otolaryngology/FPS Resident Caseload Form

SUBMIT ONE PAGE FOR EACH RESIDENT

As outlined in Standard VII-Resident Requirements, paragraph 7.4, residents are required to maintain surgical logs that must document the fulfillment of the requirements of the program describing the scope, volume and variety and progressive responsibility of the resident.

The program director, as part of the annual report of the program, must include a compilation of the major surgical cases completed* by each resident in each OGME year.

Resident's Name _____

Program Director's Assessment of the OGME-1

Were the OGME-1 training year rotations as outlined in the basic standard completed and approved? If no, include a corrective action plan to incorporate the required OGME-1 rotations. Yes No

Program Director's Assessment of the Resident's Case Load

	OGME-2		OGME-3		OGME-4		OGME-5		TOTALS
	Total	Required	Total	Required	Total	Required	Total	Required	
Congenital	_____	3	_____	3	_____	3	_____	3	12
Endoscopic Sinus	_____	15	_____	20	_____	30	_____	35	100
Endoscopy	_____	5	_____	15	_____	25	_____	45	90
Head and Neck	_____	10	_____	20	_____	30	_____	40	100
Laser	_____	5	_____	10	_____	10	_____	15	40
Otologic	_____	5	_____	15	_____	25	_____	45	90
Plastic & Recon.	_____	20	_____	35	_____	35	_____	50	140

*A major procedure in which the resident performs greater than 50% of the surgical case will be counted as a completed surgery.

PROGRAM DIRECTOR MUST OUTLINE CORRECTIVE ACTION PLAN FOR THE REMEDIATION OF MINIMUM CASE DEFICIENCY.

SCHOLARLY ACTIVITY REPORT

Title of Project	Type of Project	Points Awarded	Cumulative Points

I certify that the information on this form is correct and accurate.

Signature of Program Director	
Date	

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Signature of DME or OPTI Academic Officer	
Date	