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

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

| | | | |
|---|---|---|---|
| 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 (AOCOO-HNS) requires all program directors to complete an annual evaluation report of the program. Please submit the report within thirty (30) days of the 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 | No | |
| 2. The program director provides oversight of the resident's scholarly activity. | Yes | No | |
| 3. There is a process to evaluate and monitor quality of teaching faculty. | Yes | No | |
| 4. Does the program follow/ implement the model curriculum? | Yes | No | |
| 5. Program complies with all the patient care and educational course requirements. | Yes | No | |
| 6. Program complies with the outside rotation standard. | Yes | No | |
| 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 _____.<br>b. # who sat for Boards ____; # who passed ____<br>c. Status of those who failed: | Total mean raw score for program and nation for the past three years:<br>2020 ____ Program ____ Nation<br>2019 ____ Program ____ Nation<br>2018 ____ Program ____ Nation |
| **Fill Rate** | **Segregated Totals** |
| a. I filled ____% of my approved/authorized/funded training slots last July.<br>b. Total number of filled positions ____<br>c. Total number of approved positions ____ | Average cumulative amount of procedures completed by the residents for the last three years<br>____ 2020 ____ 2019 ____ 2018 |

| Site Visit | |
|---|---|
| **Date of last Site Visit:** | **Number of years granted for accreditation:** |
| List deficiencies from last site visit and how/when the deficiencies were corrected: | |
| List attributes and shortcomings of the program as you see them and provide the AOCOO-HNS with a Five-Year Improvement Plan for the program: | |

| Resident Information | | | |
|---|---|---|---|
| **Name** | **OGME Level** | **E-Mail** | **AOA Number** |
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| List the names of residents who left the program (i.e. transfer/withdraw) and the reason for the departure. | | | |
| Provide a Resident Status Report to indicate residents who were denied advancement and any remediation plans instituted for residents: | | | |

| Program Changes |
|---|
| If applicable, please describe any substantive changes to the program in the following areas: |

| | |
|---|---|
| Faculty | |
| Administration/Staff | |
| Training Sites | |
| Rotations | |
| Other (concerns, challenges, accomplishments) | |

| Support | | | |
|---|---|---|---|
| Are you receiving the necessary support from your OPTI? | Yes | No | Comments: |
| Are you participating in mid cycle reviews with your OPTI? | Yes | No | Comments: |
| Are you receiving the necessary support from your institution? | Yes | No | Comments: |

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

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

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***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 Resident's Case Load**

| | OGME-1 | | OGME-2 | | OGME-3 | | OGME-4 | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Total** | **Required** | **Total** | **Required** | **Total** | **Required** | **Total** | **Required** | **TOTALS** |
| Congenital | _____ | 3 | _____ | 3 | _____ | 3 | _____ | 3 | **12** |
| Endoscopic Sinus | _____ | 15 | _____ | 20 | _____ | 30 | _____ | 35 | **100** |
| Endoscopy | _____ | 5 | _____ | 15 | _____ | 25 | _____ | 45 | **80** |
| Head and Neck | _____ | 10 | _____ | 20 | _____ | 30 | _____ | 40 | **100** |
| Laser | _____ | 5 | _____ | 10 | _____ | 10 | _____ | 15 | **40** |
| Otologic | _____ | 5 | _____ | 15 | _____ | 25 | _____ | 45 | **80** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 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 CORRECTION ACTION PLAN FOR THE REMEDIATION OF MINIMUM CASE DEFICIENCY.**

_____

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***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 | |