**National Institute for Health Specialties**

**Training Capacity Modification form**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **GENERAL INFORMATION** | | | | | | | | | |
| **A. Program and Sponsoring Institution Information** | | | | | | | | | |
| Name of Program: | | | Click or tap here to enter text. | | | | | | |
| Name of Sponsoring Institution: | | | Click or tap here to enter text. | | | | | | |
| Start date: | | | Click or tap here to enter text. | | | | | | |
| Training years: | | | Click or tap here to enter text. | | | | | | |
| Number of resident positions: | | | Click or tap here to enter text. | | | | | | |
| Type of program: | | | Residency  Fellowship | | | | | | |
| **B. Key Contacts** | | | | | | | | | |
| *Program Director* | | | | | | | | | |
| Title | | | Click or tap here to enter text. | | | | | | |
| Full Name | | | Click or tap here to enter text. | | | | | | |
| Position | | | Click or tap here to enter text. | | | | | | |
| Telephone | | | Click or tap here to enter text. | | | | | | |
| Email | | | Click or tap here to enter text. | | | | | | |
| 1. **TRAINING CAPACITY MOIDFICATION** | | | | | | | | | |
| 1. **Increment** | | |  | | | | | | |
| 1. **Decrement** | | |  | | | | | | |
| 1. **Current Training Capacity:** | | | | | | | | | |
| Total No. of Residents | | | No. of Residency training years | | | | No. of Residents per Year | | |
| Click or tap here to enter text. | | | Click or tap here to enter text. | | | | Click or tap here to enter text. | | |
| 1. **Requested Training Capacity:** | | | | | | | | | |
| Total No. of Residents | | | No. of Residency training years | | | | No. of Residents per Year | | |
| Click or tap here to enter text. | | | Click or tap here to enter text. | | | | Click or tap here to enter text. | | |
| 1. **Justification for the changes on training capacity:** | | | | | | | | | |
| What is the justification for modifying the training capacity?  Click or tap here to enter text. | | | | | | | | | |
| 1. **CINICAL SERVICE INFORMATION** | | | | | | | | | |
| Institution | Specialty Department | Number of general physicians | Number of specialist physicians | Number of consultant physicians | | Number of beds | Number of inpatient admission/ month | Number of outpatient visits/month | Description / Additional Information |
| Institution # 1 |  |  |  |  | |  |  |  |  |
| Institution # 2 |  |  |  |  | |  |  |  |  |
| Institution # 3 |  |  |  |  | |  |  |  |  |
| 1. **SUPPORTED DOCUMENTS** | | | | | | | | | |
| List and attach all supportive documents for the application | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | |
| 1. **SIGNATURE OF PROGRAM DIRECTOR AND DIO** | | | | | | | | | |
| To be completed by the Program Director and DIO of entity applying for Training Capacity Modification Request | | | | | | | | | |
| Program Director Signature | | | | | Click or tap here to enter text. | | | | |
| Date | | | | | Click or tap here to enter text. | | | | |
| DIO Signature: | | | | |  | | | | |
| Date | | | | | Click or tap here to enter text. | | | | |