National Institute for Health Specialties
Common Program Information Form

1. GENERAL INFORMATION		
1 Application Information		
Date:	Click or tap here to enter text.	
Application Type:	☐ New (Initial Accreditation Application) ☐ Renewal (Continued Accreditation Application)	
2 Program and Sponsoring Institution Information		
Title of Program:		
Name of Sponsoring Institution:		
Address:		
Hospital/Center:		
PO Box:		
Institutional Education / Academic Affairs Director (Designated Institutional Official):		
Email:		
Start date:		
Accreditation and/or Certification body (if applicable provide evidence of current accreditation letters in the appendix such as Arab Board, ACGME-I, Royal College (letters without citations), etc.):	☐ Yes	☐ No
If Yes, Specify Accreditation Body	Accreditation Body	Date of Initial Accreditation
Training years:		

Number of approved resident/ fellow positions (Resident Complement):	Per Residency/ fellowship Year: Click or tap here to enter text.	Per Program: Click or tap here to enter text.
Program Requires Dedicated Research Year Beyond Accredited Program Length.	☐ Yes	☐ No
Program Requires Prior or Additional Accredited GME Training:	☐ Yes	☐ No
If yes, mention the number of Prior or Additional Accredited GME Training Years:		
Remarks / Additional Information:		

3 Program Leadership

Program Director

Name:	
Address:	
Telephone:	
Email:	
Date First Appointed as Program Director:	
Previous Director Name:	

Program Coordinator

Name:	
Address:	
Telephone:	
Email:	

4 Program Vision and Mission

Provide brief statements about the program, mission statement, and list the major achievements, major challenges, concerns and limitations (SWOT Analysis is desirable).

(*The mission statement is a written statement of a program's core purpose. This statement should clarify the focus of the educational program (e.g., academic/research focus, community care focus, etc.), what community the program will serve and how that will be accomplished, and how the program's mission aligns with the larger mission of the Sponsoring Institution)*

Click or tap here to enter text.

5 The Program Aims

The program's aims should describe what the program has the intention of achieving in accordance with the Common Program Requirements. The program aims should be consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates serve, and the distinctive capabilities of its graduates (e.g., leadership, research, public health).

Click or tap here to enter text.

6 Program Director

What percent of FTE salary support is allocated to the program director for non-clinical time devoted to the administration of this program?

Click or tap here to enter text.

Number of Hours Per Week Director Devotes to Program Activities in the Following:

Clinical Supervision:	Administration:	Research:	Didactics/Teaching:

Certification(s) (add rows as required)

Certification	Year

7 Associate Program Director

What percent of FTE salary support is allocated to the associate program director(s) for non-clinical time devoted to the administration of the program? If not applicable, enter "N/A" in the response.

Click or tap here to enter text.

8 Program Coordinator

How many hours of salary support per week are allocated to the program coordinator for administrative duties?

Click or tap here to enter text.

2. PROGRAM FACILITIES AND RESOURCES

1 Program Facilities Information

Provide a detailed description of the program facilities (physical infrastructure, particularly in relation to space requirements and configuration of premises).

Click or tap here to enter text.

2 Basic Data of the Sponsoring Department / Service (For Hospital Based Specialities)

Complete the below table concerning basic data of the Sponsoring Department / Service.

Specialty sponsoring department	Number of general physicians	Number of specialist physicians	Number of consultant physicians	Number of beds	Number of inpatient admission/ months	Number of outpatient visits/month	Description / Additional Information

Amenities:

☐ Safe, quiet, clean, and private sleep/rest facilities available and accessible with proximity appropriate for safe patient care (not required for dental specialities)

☐ Shower (not required for dental specialities)

☐ Secure areas (lockers or rooms that can be locked)

☐ Access to food.

☐ Parking accessible to site

☐ Internet Access

☐ Reasonable accommodations for residents/fellows with disabilities consistent with the Sponsoring Institution's policy

☐ Clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care

☐ None of the Above

3 Basic Data of the Sponsoring Department / Service (For Dental Specialities)

Complete the below table concerning basic data of the Sponsoring Department / Service.

Specialty sponsoring department	Number of general dentists	Number of specialist dentists	Number of consultant dentists	Number of clinical chairs	Number of patient visits/ month	Description /Additional Information

4 Data of the Participating Sites.

Complete the below table concerning the participating sites: (Add rows as required)

Participating sites	Site Director	PLA Date	Joint Commission International approved (Yes / No)	Type of Rotation (Required/Non required)	Length of Rotation (In months)	Year of Rotation	Educational Rational

3. MEDICAL/ DENTAL EDUCATION ACTVITITES.

Residents / Fellows and staff medical/ dental education activities

1. Complete the below table concerning Residents / Fellows and staff medical/ dental education activities.

Activities	Availability	Description / Additional Information
Clinical meetings such as morning reports, multidisciplinary meetings etc.	☐	
Didactics academic program	☐	
Grand rounds	☐	
Journal clubs and evidence-based reviews	☐	
CME / Conferences / Workshops	☐	
Mortality and Morbidity	☐	
Case-based discussions	☐	
Computer-aided online learning	☐	
Others (specify:)	☐	

2. Describe the training / consulting facilities / equipment available in your organization (e.g., lecture rooms, library, conference halls, meeting rooms, audio-visual aids, computers, data-show, laptop, white board, etc.).

Click or tap here to enter text.

4. FACULTY INFORMATION

Faculty information

A. Complete the following table: (for your convenience, you may submit it as separate attachment)

Name of faculty as written in passport:	Faculty Type: (faculty, core faculty, PD, APD)	Gender:	Nationality:	Emirates ID:	Date of Birth:	Email:	Mobile:	Date first appointed in your current position:

B. Number of hours per week faculty member devotes to this program's activities in the following:

Name of faculty as written in passport:	Clinical Supervision of Residents	Administration of the program	Research	Didactics/Teaching with residents	Total hours devoted to this program.	Case Log Attendings (Active) Yes\No

C. Academic Qualifications

Name of faculty as written in passport:	Institution/University	Degree Level	Degree Title	First Attend	Last Attend	Graduation Date

D. Specialty Certifications:

Name of faculty as written in passport:	Specialty	Certification Board or Equivalent	Certification Date	Formal Trainer Yes\No	If yes, Training Institution\ University	Postgraduates Training (Residents\fellowship\ other and specify)	First attended.	Last attended.

E. Licensing:

Name of faculty as written in passport:	Licensing Number:	Licensing Authority:	Licensed As: (Consultant, specialist, GB, Nurse, Residents, fellows, other and specify)	Specialty as written in medical licensing:	Expiration Date:	Health Facility Name:

F. Professional Experience

Name of faculty as written in passport:	Academic Position (DIO, PD, APD, Faculty, Other and Specify)	Start Date	End Date	Organization	Summary of duties and responsibilities
	Current				

G. Teaching Program Details

Name of faculty as written in passport:	Specialty Name	Year	Institution	Role	FTE

H. Awards and Honors

Name of faculty as written in passport:	Type	Awards and Honors	Awarded By	Country	Date Awarded	Expiry Date

I. Scholarly Activities

Name of faculty as written in passport:	PMID (Not Mandatory)	Publication Title	Publication Date	Publisher\Journal	Role (First Author, Corresponding, Co Author)	Type of Publication (Journal Articles, Case report, letter, Clinical Trial, Conference Abstract, Book and Documents, Editorial, Review)	Research Interest:

J. Core Faculty to Resident/ Fellow Ratio:

Click or tap here to enter text.

K. Faculty to Resident/ Fellow Ratio:

Click or tap here to enter text.

L. Describe the process to maintain faculty development and enhance their teaching interest.

Click or tap here to enter text.

M. With regards to Faculty Development, in which areas have program faculty participated in faculty development over the past year?	☐ as educators ☐ in quality improvement and patient safety ☐ in fostering their own and their residents'/fellows' well-being ☐ in patient care based on their practice-based learning and improvement efforts ☐ None of the above

N. Do you have a performance assurance and reward system for the faculty? If yes, describe below.

☐ Yes

☐ No

Click or tap here to enter text.

O. Describe Faculty involvement in the program planning and ongoing program review and evaluation.

Click or tap here to enter text.

5. RESIDENTS/ FELLOWS INFORMATION

Residents/ Fellows information

A. Complete the below table about the actively enrolled residents/ fellows in the program (add rows as required)

Name as written in passport:	Gender:	Nationality:	Emirates ID:	Date of Birth:	Email:	Mobile:	Residents/ Fellows current status (active, completed training, inactive)	Residency/ Fellowship Year (PGY):	Program Start Date:	Expected Completion Date:

B. Complete the below table about the actively enrolled residents/ fellows in the program (add rows as required)

Name as written in passport:	Did these residents/ fellows start the program in year one (at the beginning of the program - no transfer credit)?	If no, did these residents/ fellows have prior training in another accredited program?	If yes, specify the program and accreditation body

C. Academic Qualifications

Name as written in passport:	Institution/ University	Degree level (Bachelor's Degree, MBBS, MD, Diploma (Above Secondary), Other and Specify)	Degree Title	First Attend	Last Attend	Graduation Date

P. Specialty Certifications:

Name as written in passport:	Specialty	Certification Board or Equivalent	Certification Date	Formal Trainer Yes\No	If yes, Training Institution\ University	Postgraduates Training (Residents\fellowship\other and specify)	First attended.	Last attended.

Q. Licensing:

Name as written in passport:	Licensing Number:	Licensing Authority:	Licensed As: (Consultant, specialist, GB, Nurse, Residents, fellows, other and specify)	Specialty as written in medical licensing:	Expiration Date:	Health Facility Name:

R. Awards and Honors

Name as written in passport:	Type	Awards and Honors	Awarded By	Country	Date Awarded	Expiry Date

S. Scholarly Activities

Name as written in passport:	PMID (Not Mandatory)	Publication Title	Publication Date	Publisher\Journal	Role (First Author, Corresponding, Co Author)	Type of Publication (Journal Articles, Case report, letter, Clinical Trial, Conference Abstract, Book and Documents, Editorial, Review)	Research Interest:

D. Did the residents/ fellows have official licensing and privileging process? Describe.

Click or tap here to enter text.

E. Describe research training and opportunities for residents/ fellows to participate in scholarly activities.

Click or tap here to enter text.

F. List residents'/ Fellow's final board pass rate for the last 3 years.

Click or tap here to enter text.

G. What is the process of resident's/ fellow's transfer; withdrawal; and termination from program? Can the residents/ fellows return to the program?

Click or tap here to enter text.

H. Complete the below table by listing the residents/ fellows who were transferred, withdraw and terminated from the program in the past 5 years, as well add the reason beside every resident's/ fellow's name:

Year	Residents/ Fellows Transferred from the Program (Name and Reason)	Residents/ Fellows Withdraw from the Program (Name and Reason)	Residents/ Fellows terminated from the Program (Name and Reason)

I. Are you requesting residents/ fellows complement change?	☐Yes	☐No
J. If yes to the above question, what is the recommended positions per residency/ fellowship year:	Addition No: Click or tap here to enter text.	Deleted No: Click or tap here to enter text.

K. Rational: Click or tap here to enter text.

6. PROGRAM CURRICULUM AND POLICIES

1. Describe the process of resident's/fellow's evaluation.	Click or tap here to enter text.
2. Describe the arrangements for residents'/ fellow's safety and wellbeing including duty hours, access to required facilities, counselling and support.	Click or tap here to enter text.
3. List the promotion criteria per each graduate year, graduation requirements and the Summative Letter.	Click or tap here to enter text.
4. How will the faculty provide appropriate supervision of residents/fellows in patient care activities?	Click or tap here to enter text.
5. How will the program ensure that residents/fellows comply with the NIHS duty hour standards?	Click or tap here to enter text.
6. Does the program provide residents/fellows with the opportunity to attend medical, mental health and dental care appointments?	☐ Yes ☐ No
7. Does the program educate faculty members and residents/fellows in identification of the symptoms of burnout, depression and substance abuse?	☐ Yes ☐ No
8. Does the program educate faculty members and residents/fellows to recognize symptoms of burnout, depression and substance abuse in themselves and to seek appropriate care?	☐ Yes ☐ No
9. How will the program ensure that resident/fellow education is not adversely affected by heavy service obligations?	Click or tap here to enter text.
10. How are residents/fellows and faculty informed about their assignments, the duties expected of each rotation, and the goals and objectives for each assignment? Check all that apply:	☐ Hard copy ☐ Electronic copy ☐ Website ☐ Distributed at in person meeting ☐ Other ☐ Residents/fellows are not informed for each rotation

11. What other learners will be sharing educational or clinical experiences with the residents/fellows? Check all that apply:	☐ Medical/ Dental students ☐ Residents/fellows from other programs ☐ Advanced practice professional students ☐ Advanced practice professional staff ☐ Other health professions students ☐ Other health professions staff ☐ None of the above
12. What are your program's top priorities for improving the learning and working environment for residents/fellows with brief description?	Click or tap here to enter text.
13. Describe the process for residents/fellows to deal with and/or report problems and concerns to the Program Director, faculty, GME Office, Sponsoring Institution, etc. (The answer must describe the mechanism by which individual residents/ fellows can address concerns in a confidential and protected manner as well as steps taken to minimize fear of intimidation or retaliation.)	Click or tap here to enter text.
14. Describe how the program educates residents/fellows on the identification and reporting of near misses, adverse events, and serious adverse events. This should include how these are communicated to patients and families. This may include simulation training, didactic and conference presentations, direct patient experiences, etc.	Click or tap here to enter text.
15. Indicate which methods the program uses to ensure that hand-off processes facilitate both continuity of care and patient safety?	Click or tap here to enter text.
16. Describe how the recommendations, suggestions and citations that resulted from the last program accreditation survey report have been addressed (If applicable)	Click or tap here to enter text.
17. Provide a brief description of any cultural or health delivery system characteristics that you believe impedes the educational program's substantial compliance with NIHS Specialty Requirements. Describe how you have or plan to address each so	Click or tap here to enter text.

that you will substantially meet the intent of the requirement.	
7. EVALUATION	
1. Will the program have a system in place to evaluate the resident/fellows' abilities to determine whether they may take on progressive authority and responsibilities in patient care?	☐ Yes ☐ No
2. Indicate how the Program Director and faculty members are educated to use assessment methods so that residents/fellows are evaluated fairly and consistently. Select up to 3 of the most commonly used methods.	☐ Workshops/special training on assessment ☐ Informal or formal discussions among the faculty ☐ Assessment is a topic of a retreat ☐ Faculty review assessments and compare evaluations ☐ PD instructs or educates about assessment methods ☐ Group or committee discussions that result in consensus assessment of residents/fellows ☐ None, no specific education on assessment provided ☐ Other (specify below)
Specify only if Other is selected:	Click or tap here to enter text.
3. Indicate how residents/fellows will be informed of the performance criteria on which they will be evaluated. Check all that apply.	☐ During resident/fellow orientation ☐ Program goals and objectives ☐ Rotation-specific goals and objectives ☐ Provided handouts or examples of evaluation forms ☐ Other written communications ☐ Verbal communication or meetings ☐ Reviewed with residents/fellows before each rotation ☐ Reviewed with residents/fellows at the beginning of each year ☐ Residents/fellows not informed ☐ Other (specify below)
Specify only if Other is selected:	Click or tap here to enter text.
4. Describe the system, which ensures that faculty will complete written evaluations of residents/fellows in a timely manner following each rotation or educational experience.	Click or tap here to enter text.
5. List the members of the Clinical Competency Committee	Click or tap here to enter text.

6. List the members of the Program Evaluation Committee	Click or tap here to enter text.
7. Does the program director or a program director designee meet with each resident/fellow on a semi-annual basis to provide feedback on their performance including progress on Milestones?	Click or tap here to enter text.

8. APPENDIX

Attach the following documents in the Appendix

1. Residency/ Fellowship training program manual including Competency Goals and Objectives for the program assignments.
2. Residency/ Fellowship training program policies and procedures manual.
3. If applicable, program accreditation letters such as Arab Board, ACGME-I, Royal College (letters without citations), etc.
4. Sample of didactic program and attendance record template.
5. Current curriculum vitae for the Program Director
6. Delegation letter signed by the Program Director and his/her designee to ensure continuity of work i.e., to perform duties in his/her absence.
7. Graduate medical/ dental education policy on eligibility and selection of residents/ fellows.
8. Graduate medical/ dental education policy on resident's/ fellow's duty hours.
9. Graduate medical/ dental education policy on education and work environment.
10. Graduate medical/ dental education policy on supervision. Comprised of the policy for supervision of residents/ fellows, which addresses residents'/ fellows' responsibilities for patient care and progressive responsibility for patient management, as well as faculty responsibilities for supervision.
11. Graduate medical/ dental education policy on evaluation.
12. Provide copy of the program evaluations Tools- Represents a blank copy of program specific tools that are used to measure the competencies.
13. Provide copy of the program Summative evaluation - (Documenting performance during the final period of education and verifying that the resident/ fellow has demonstrated sufficient competence to enter autonomous practice).
14. Faculty and residents/fellows Emirates ID Copy.
15. Faculty and residents/fellows' health Professional License.
16. Sample of faculty evaluation.
17. Sample of faculty and residents/fellows Awards and Honors.

9. DECLARATION BY DIO & PROGRAM DIRECTOR

This declaration must be completed by the Designated Institutional Official and Program Director of the Program applying for Program Accreditation.

I hereby declare that the information I have provided in this application form and attached as supporting evidence are valid. I understand that should this application for Accreditation be successful, the Program must be able to demonstrate compliance on the *National Institute for Health Specialties* Accreditation Requirements and Bylaws for continued accreditation.

I understand that this application may be rejected or cancelled if the Program does not provide the necessary evidence or fails to provide valid information.	
Program Director	
Name	
Signature	
Date	
Designated Institutional Official	
Name	
Signature	
Date	