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VLM Fellowship Program Application

# General Information

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 current Venous & Lymphatic Medicine (VLM) Fellowship program. For items that do not apply indicate N/A in the space provided. Where patient numbers are requested, please be accurate. If any requested information is not available, an explanation should be given and it should be so indicated in the appropriate place on the form.

# Required Elements

* Use Arial or Calibri font, 10 or 12 point font size
* Full application in word or pdf format emailed to Info@ABVLM.org
* Send one hard copy to: American Board of Venous & Lymphatic Medicine (ABVLM) Headquarters: 781 Beach Street, Suite 302, San Francisco, CA 94109
* Keep required elements in order
* Include page numbers (fill in table of table of contents with page numbers)

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| * Policy for supervision of fellows (addresses fellow’s responsibilities for patient care and progressive responsibility for patient management and faculty responsibilities for supervision)
* Program policies and procedures for fellow duty hours and work environment.
* Overall educational goals for the program
* A sample of competency-based goals and objectives
* Any Assessment tools, evaluation forms or documents used to monitor Fellow
* Fellow application process, contracts, policies for discipline, dismissal, or due process
* Recommendation Letters
 |  |

#  Program Name

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# Accreditation Information

|  |
| --- |
| Date:  |
| Title of Program:  |
| Requested Effective Date of Accreditation:  |
| Status of core program, if applicable: |
| Length of program:  |
| Number of requested fellow positions:  |
| The signatures of the director of the program and the designated institutional official attest to the completeness and accuracy of the information provided on these forms. |
| Name of Program Director:  |
| Signature of Program Director (and date): |
| Name of Designated Institutional Official (DIO):  |
| Signature of DIO (and date): |

# Respond to Previous Citation(s)

If the program reapplies for accreditation within two years after accreditation has previously been withdrawn or proposed withdrawn, the accreditation history of the last accreditation action of that program shall be included as part of the file.

a) In the case of application after proposed withdrawal, provide a statement rebutting each citation and documenting compliance with American Board of Venous & Lymphatic Medicine requirements or provide a response to b) below.

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b) In case of application after either proposed withdrawal or withdrawal, provide a statement of the measures the program has taken to comply with ABVLM requirements relating to each citation in the last letter of accreditation.

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# Participating Sites

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| --- |
| **SPONSORING INSTITUTION:** (The university, hospital, or foundation that has ultimate responsibility for this program.)  |
| Name of Sponsor:  |
|  Address:  | Single Program Sponsor? | ( ) YES | ( ) NO |
| City, State, Zip code:  |
| Type of Institution: (e.g., Teaching Hospital, General Hospital, Medical School) University / Hospital |
| Name of Designated Institutional Official:  |
| Mailing Address:  | Phone Number:  |
| Email:  |
| Name of Chief Executive Officer:  |
| 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 #1:  |
| Name of Medical School #2:  |

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| **PRIMARY CLINICAL SITE (Site #1)**  |
| Name:  |
|  Address:  |
| City, State, Zip Code:  |
| Clinical Site?  | ( ) YES | ( ) NO |  |
| Type of Rotation (select one) | Elective ( )  | Required ( )  | Both ( )  |  |
| Length of Fellow Rotations (in months) | Year 1: 12 months |  |   |  |  |  |
|  |  |  |  |  |  |  |
| CEO/Director/President’s Name:  |
| Joint Commission Approved? ( ) YES ( ) NO  |
| If no, explain:  |

The Program Director must submit any participating sites routinely providing an educational experience, required for the fellow, of one month full time equivalent (FTE) or more. Please duplicate as necessary.

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| **PARTICIPATING SITE (Site #2)**  |
| Name:  |
| Address:  |
| City, State, Zip Code  |
| Integrated: ( ) YES ( ) NO |  |  |
| Does this site also sponsor its own program in this specialty? | ( ) YES | ( ) NO |
| Does it participate in any other ACGME-accredited programs in this specialty? | ( ) YES | ( ) NO |
| Distance between #2 & #1:  | Miles:  |  | Minutes: |   |
| Type of Rotation (select one)  | ( ) Elective | ( ) Required  | ( ) Both |  |
| Length of Fellow Rotations (in months) | Year 1:  |   |  |  |  |  |
|  |  |  |  |  |  |  |
| CEO/Director/President’s Name: |   |
| Brief Educational Rationale: |  |

1. Provide an institutional statement that commits the necessary financial, educational, and human resources to support the GME program(s) and provide documentation that the statement has been approved by the governing body, the administration and the teaching staff.

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| **Institutional Commitment to Graduate Medical Education**  |

1. Describe the formal method by which a periodic evaluation of the program’s educational quality and compliance with the program requirements will occur. Explain how fellow and faculty in the program will be involved in the evaluation process.

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1. Describe how the institution will comply with the Institutional Requirements regarding “Fellow Eligibility and Selection” and the development of appropriate criteria for the selection, evaluation, promotion and dismissal of fellow in accordance with the Program and Institutional Requirements.

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1. Describe in detail the grievance (due process) procedure(s) that will be available to fellow, including the composition of the grievance committee, and mechanisms for handling complaints and grievances related to actions which could result in dismissal, non-renewal of a fellow’s contract, or other actions that could significantly threaten a fellow’s intended career development.

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#  Program Personnel and Resources

## Program Director Information

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| --- |
| Name:  |
| Title:  |
| Address:  |
| City, State, Zip code:  |
| Telephone:  | FAX:  | Email:  |
| Date First Appointed as Program Director:  |
| Will Your Principal Activity Be Devoted to Fellow Education?  | ( ) YES | ( ) NO |
| Term of Program Director Appointment:  |
| Date first appointed as faculty member in the program:  |
| Percentage of time the program director devotes to the program in the following activities: |
| Clinical Supervision: |  | Administration: |   | Research: |   | Didactics/Teaching: |  |
| Primary Specialty Board Certification:  | Most Recent Year:  |
| Secondary Specialty Board Certification:  | Most Recent Year:  |
| Number of years spent teaching in GME in this specialty:  |

1. Does the program director approve the selection of program faculty as appropriate?
 ( ) YES ( ) NO
2. Will the program director evaluate the faculty and approve the continued participation of program faculty based on evaluation? ( ) YES ( ) NO
3. Will the program director comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellow, disciplinary action, and supervision of residents? ( ) YES ( ) NO
4. Is the program director familiar with and does he/she comply with ACGME and RC policies and procedures as outlined in the ACGME Manual of Policies and Procedures? ( ) YES ( ) NO

## Physician Faculty Roster

List alphabetically and by site all physician faculty who devote at least 5 hours a week to fellow education. Using the form provided below, supply a one page CV for every faculty listed.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name (Position)** | **Degree** | **Based Primar-ily at Site #** | **Primary and Secondary Specialties / Fields** | **Years as Faculty in Spec-ialty** | **Average Hours Per Week Spent On:** |
| **Specialty / Field** | **Board Certification (Y/N)†** | **Most Recent Certification Date** | **Clinical Supervision** | **Admin** | **Didactic Teaching** | **Research** |
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† Certification for the primary specialty refers to ABMS Board Certification. Certification for the secondary specialty refers to sub-Board certification.

# Faculty Curriculum Vitae

(Insert CV’s here. Limit 1 page per person, except for Program Director)

# Non Physician Faculty Roster

List alphabetically the non-physician faculty who will provide required instruction or supervision of fellow in the program. In addition, provide a one page CV for each non-physician faculty listed using the form provided below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name (Position) | Degree | Based Primarily at Site # | Specialty/Field | Role In Program | Years as Faculty in Specialty |
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# Non Physician Faculty Curriculum Vitae

(Limit 1 page per person)

# Fellowship Appointments

|  |  |
| --- | --- |
| **Positions per year** |   |
| **Total Number of Requested Positions** |   |

1. Describe how fellow will be informed about their assignments and duties.

[The answer must confirm that there are goals and objectives for each assignment and for each year, and that these will be readily available (hard copy, electronically, listserv, etc.) to all fellows.]

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

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

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**E. Evaluation (Fellows, Faculty, Program)**

1. Will fellow(s) be evaluated on their performance following each learning experience?
 ( ) YES ( ) NO

If no, explain

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

If no, explain

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3. Using the table below (add rows as needed):

a) Provide the methods of evaluation used for assessing fellow competence in each of the six required ACGME competencies and,

b) Identify the evaluators for each method (e.g., “performance in patient care is evaluated by global forms completed by faculty and fellow, observed histories and physicals by the ward attending and the continuity preceptor; medical knowledge is assessed through the In-Training Examination [developed by the institution now and in the future nationally] and an evidence-based journal club evaluated by the PD, etc.”)

**Examples of assessment methods:**

direct observation, videotaped/recorded assessment, global assessment, simulations/models, record/chart review, standardized patient examination, multisource assessment, project assessment, patient survey, in-house written examination, in-training examination, oral exam, objective structured clinical examination, structured case discussions, anatomic or animal models, role-play or simulations, formal oral exam, practice/billing audit, review of case or procedure log, review of patient outcomes, review of drug prescribing, fellow experience narrative and any other applicable assessment method

**Examples of types of evaluators:**

self, program director, nurse, faculty supervisor, medical student, faculty member, allied health professional, fellow supervisor, patient, other residents, technicians, clerical staff, evaluation committee, consultants.

| ***Competency*** | ***Assessment Method(s)*** | ***Evaluator(s)*** |
| --- | --- | --- |
| **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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4. Describe how evaluators will be educated to use the assessment methods listed above so that the fellow is evaluated fairly and consistently.

Limit your response to 400 words.

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5. Describe how the fellow will be informed of the performance criteria on which they will be evaluated.

Limit your response to 400 words.

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6. Describe the system that ensures that faculty will complete written evaluations of fellow in a timely manner following each rotation or educational experience.

 Limit your response to 400 words.

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7. Describe the process that will be used to complete and document written semiannual fellow evaluations, including the mechanism for reviewing results of the evaluation (e.g., who meets with the fellow and how the results are documented in fellow files).

Limit your response to 400 words.

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8. Describe the system that the fellow 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.]

Limit your response to 400 words.

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9. Describe the system that the program (or department, if applicable) will use to provide evaluation and feedback to the teaching faculty.

Limit your response to 400 words.

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10. Describe the approach that will be used for program evaluation, including how the program will ensure that the fellow provide confidential written evaluation of the program at least annually.

Limit your response to 400 words.

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**F. Fellow Duty Hours**

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| --- | --- |
| 1. Excluding call from home, what is the projected average number of hours on duty per week per fellow?
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| --- | --- |
| 1. The fellow with have 2 days per week of call from home. Any floor or ER consults for venous problems (including DVT) will be first evaluated by the in-house resident on call, and will call the VLM fellow with these consults for evaluation.
 |  |

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| --- | --- |
| 1. What is the projected average number of days per week of in-house call (excluding home call and night float) which the fellow will be assigned?
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1. How will the faculty provide appropriate supervision of the fellow in patient care activities?

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1. How will the program ensure that the fellow comply with the ACGME duty hour standards? Please be specific as regards the duty hour weekly limit, time spent on-call, days free each week, length of duty shifts, periods of rest between duty shifts, and moonlighting policies, as applicable.

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1. How will the program ensure that fellow recognize the signs of fatigue and sleep deprivation?

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1. How will the program ensure that fellow education is not adversely affected by heavy service obligations?

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#  Fellow’s Scholarly Activities

Will the program offer the fellow the opportunity to participate in scholarly activities? If yes, briefly describe the opportunity and the expectations about the fellows’ participation. [The answer must include which research skills are taught in the curriculum.]

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**ABVLM REVIEW COMMITTEE FOR Venous & Lymphatic Medicine**

**PROGRAM INFORMATION FORM**

**I. Patient Care**

**A. Institutional Operative Experience**

|  |  |  |
| --- | --- | --- |
| **Type of Procedure** | **# of procedures as First Assistant** | **# of procedures performed** |
| **Category I - Saphenous vein ablation** |  |  |
| Phlebectomy |  |  |
| Ligation and Stripping |  |  |
| RadiofrequencyLaser |  |  |
| Ultrasound guided chemical ablation |  |  |
| Sclerotherapy for spider veins |  |  |
| Catheter |  |  |
| Other |  |  |
| **Category II - Perforator vein ablation** |  |  |
| Chemical ablation  |  |  |
| Endoscopic ablation (SEPS) |  |  |
| Laser |  |  |
| radiofrequency |  |  |
| Other |  |  |
| **Category III - Management of deep venous disease** (including VTE, deep venous insufficiency, venous obstruction, venous aneurysm, venous trauma). |  |  |
| Thrombectomy (mechanical) |  |  |
| Thrombolysis |  |  |
| Venous Stenting |  |  |
| Thrombectomy (balloon) |  |  |
| Venous bypass |  |  |
| Filter placement |  |  |
| Deep Venous Reconstruction |  |  |
| Other |  |  |
| **Category IV - Management of pelvic venous insufficiency** |  |  |
| Surgical Therapy |  |  |
| Embolization |  |  |
| Chemical Ablation |  |  |
| Other |  |  |
| **Category V - Management of vascular malformation/AV fistula** |  |  |
| Surgical Therapy |  |  |
| Embolization |  |  |
| Chemical Ablation |  |  |
| Other |  |  |
| **Category VI - Management of chronic venous insufficiency (CEAP C4-C6)**  |  |  |
| Compression Therapy |  |  |
| Skin graft |  |  |
| Wound care |  |  |
| Other |  |  |
| **Category VII – Anesthesia** |  |  |
| Local |  |  |
| Tumescent |  |  |
| Blocks |  |  |
| Other |  |  |
| **Category VllI - Lymphedema** |  |  |
| Compression therapy |  |  |
| Operative intervention (YES) |  |  |
| Other |  |  |

**II. Medical Knowledge**

1. List regular conferences, basic science, clinical science, morbidity and mortality, journal club or others that are a part of the fellowships training program at the sponsoring, integrated and non-integrated sites. Indicate after each conference if it is required (R) or optional (O) for fellows and how attendance is documented.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Conference** | **Site** | **R/O** | **Frequency** | **Average % Attendance Fellow/Faculty** | **Attendance Documented by** | **Person Responsible** |
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1. Are fellows provided with protected time to attend these conferences? If no, please explain
……………………………………………………………………………………………………..( ) YES ( ) NO
2. Is there at least an every other week review of all complications and deaths on the vascular service at all participating sites? If no, please explain. ( ) YES ( ) NO
3. Is there a regular review of recent literature, such as a journal club? If no, please explain.
 ( ) YES ( ) NO
4. Is there organized clinical teaching, such as ward rounds and clinical conferences at all participating sites? If no, please explain. ( ) YES ( ) NO
5. **For INTEGRATED TRAINING PROGRAMS** Does the fellow complete the year of training under the direction and authority of the program director? If no, please explain. ( ) N/A ( ) YES ( ) NO
6. Describe how education is provided for the following components of the educational program

a) Topics not covered by patient contact (i.e. unusual clinical conditions)

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b) The fundamental sciences related to VLM

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c) Non-invasive vascular laboratory techniques and study interpretation

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d) Critical thinking, experimental design, data evaluation and fellow involvement in research

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e) Vascular imaging techniques and study interpretation

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f) Endovascular procedures

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1. Describe the inpatient experience of the VLM fellow.

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1. Does the VLM fellow participate in the diagnosis, preoperative care, operative procedure and postoperative care for the majority of the patients treated? If no, please explain. ( ) YES ( ) NO

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* 1. Does the VLM fellow spend, on average, one-half day per week in the inpatient setting? If no, please explain. ( ) YES ( ) NO

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*While the ABVLM follows the guidelines of the ACGME for Training Programs ,the ABVLM expects that all VLM fellowship programs demonstrate compliance with the ACGME general competencies, the RC has decided that completion of Sections III through VI of the VLM PIF (the sections pertaining to Practice-Based Learning and Improvement; Interpersonal and Communication Skills; Professionalism; and Systems-based Practice) is optional. The RC continues to be interested how all six competencies have been integrated into the program. The Fellowship field representative assigned to your program will assess this during the site visit.*

**Please describe the planned program learning activities which will provide experience in the general competencies for the fellow.** Examples of learning activities include: didactic lecture, assigned reading, seminar, self-directed learning module, conference, small group discussion, workshop, online module, journal club, project, case discussion, one-on-one mentoring.

**III. Practice-based Learning and Improvement** (PR IV.A.5.c))

1. Describe one learning activity in which the fellow will engage to identify strengths, deficiencies, and limits in their knowledge and expertise (self-reflection and self-assessment); set learning and improvement goals; identify and perform appropriate learning activities to achieve self-identified goals (life-long learning).

Limit your response to 400 words.

|  |
| --- |
| Participation in a weekly,  |

2. Describe one learning activity in which the fellow will engage to develop the skills needed to use information technology to locate, appraise, and assimilate evidence from scientific studies and apply it to their patients’ health problems. The description should include:

a) locating information

b) using information technology

c) appraising information

d) assimilating evidence information (from scientific studies)

e) applying information to patient care

Limit your response to 400 words.

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3. Describe one planned quality improvement activity or project in which at least the fellow will participate that will require the fellow to demonstrate an ability to analyze, improve and change practice or patient care. Describe planning, implementation, evaluation and provisions of faculty support and supervision that will guide this process.

Limit your response to 400 words.

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4. Describe how the fellow will:

a) develop teaching skills necessary to educate patients, families, students, and other residents;

b) teach patients, families, and others; and,

c) receive and incorporate formative evaluation feedback into daily practice. (If a specific tool is used to evaluate these skills have it available for review by the site visitor.)

Limit your response to 400 words.

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**IV. Interpersonal and Communication Skills**

1. Describe one learning activity in which the fellow will develop competence in communicating effectively with patients and families across a broad range of socioeconomic and cultural backgrounds, and with other physicians, other health professionals, and health related agencies.

Limit your response to 400 words.

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2. Describe one learning activity in which the fellow will develop their skills and habits to work effectively as a member or leader of a health care team or other professional group. In the example, identify the members of the team, responsibilities of the team members, and how team members communicate to accomplish responsibilities.

Limit your response to 400 words.

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3. Explain (a) how the completion of comprehensive, timely and legible medical records will be monitored and evaluated; and (b) the mechanism that will be used for providing the fellow feedback on his/her ability to maintain medical records.

Limit your response to 400 words.

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#  Professionalism

1. Describe one learning activity, other than lecture, by which the fellow will develop a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Limit your response to 400 words.

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2. How will the program promote professional behavior by the fellow and faculty?

Limit your response to 400 words.

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3. How will lapses in these behaviors be addressed?

Limit your response to 400 words.

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# Systems-Based Practice

1. Describe the learning activities through which the fellow will achieve competence in the elements of systems-based practice. Examples of such activities would include: work effectively in various health care delivery settings and systems, coordinate patient care within the health care system; incorporate considerations of cost-containment and risk-benefit analysis in patient care; advocate for quality patient care and optimal patient care systems; and work in inter-professional teams to enhance patient safety and care quality.

Limit your response to 400 words.

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2. Describe an activity that will provide experiential learning in identifying system errors.

Limit your response to 400 words.

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#  Description of VLM Fellowship Program

Provide the answer to the specific questions and provide a concise narrative where requested. In preparing this portion of Program Information Form follow the format and number all pages consecutively. Do not leave any items without response.

## Fellow

1. Is the fellow appointed by the program director? ( ) YES ( ) NO

## **Relationship with Vascular Surgery**

1. Is there a general surgery, interventional radiology, and dermatology residency training program in the sponsoring institution? ( ) YES ( ) NO

2. Do the VLM, Vascular, and Dermatology program directors coordinate activities for the integrated program?
 ( ) YES ( ) NO

If no, please explain

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|  |

3. In the table below provide the program average number of defined category VLM procedures performed in the associated programs for each year since the last program review.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** |  |  |  |  |  |
| **Case Number** |  |  |  |  |  |

4. What was the least number of defined category VLM procedures performed by any individual resident in the associated programs since the last program review? ( ) Number

5. Describe the relationship between the VLM fellow and any fellows on different services, specifically how the lines of responsibility are defined and what the impact is of the VLM fellow on the educational experience of the other fellows and vice versa.

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##  Program Director Requirements

1. Provide the following information about the program director:

a) Is the program director certified in VLM by the ABVLM? ( ) YES ( ) NO

b) Is the program director’s term of appointment at least the length of the training program + 1 year?

 ( ) YES ( ) NO

c) Is the program director on-site and active in the program or active as a member of the larger program’s faculty ?

 ( ) YES ( ) NO

d) Has the program director prepared written educational goals and objectives for the program?
 ( ) YES ( ) NO

e) Has the program director distributed the goals and objectives to the fellow?
 ( ) YES ( ) NO

f) Has the program director distributed the goals and objectives to the teaching faculty?
 ( ) YES ( ) NO

g) Has the program director written explicit supervisory lines of responsibility for the care of the patients?

 ( ) YES ( ) NO

h) Does the program director coordinate the overall teaching activities of the program?
 ( ) YES ( ) NO

1. Does the program director have control over the year of VLM training? ( ) YES ( ) NO
2. Does the program director make the fellow aware of institutional policies and procedures regarding academic discipline, fellow complaints and fellow grievances? ( ) YES ( ) NO
3. Describe how the program director makes fellow aware of the policies and procedures:

|  |
| --- |
|   |

1. Does the program director monitor fellow stress, including mental or emotional conditions inhibiting performance or learning and substance-abuse related dysfunction? ( ) YES ( ) NO
2. Describe how the program director monitors fellow stress.

|  |
| --- |
|   |

##  Faculty

1. Provide the following information about the faculty involved in teaching the VLM fellow:

|  |  |  |  |
| --- | --- | --- | --- |
| **Discipline** | **Number on Teaching Faculty** | **Number Certified by Specialty Board** | **Number Full-time** |
| Vascular surgery |  |  |  |
| General surgery |  |  |  |
| Radiology |  |  |  |
| Dermatology |  |  |  |
| Other (Please specify discipline) |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

2. Describe the role of faculty from all disciplines other than the Phlebologist in the training of the VLM fellow.

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## Program Resources

1. Is the program provided with sufficient professional, technical and clerical personnel to support the administration and educational conduct of the program? ( ) YES ( ) NO

If no, please explain.

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|  |

1. Does the fellow have access to a non-invasive vascular laboratory? ( ) YES ( ) NO

If no, please explain.

|  |
| --- |
|  |

1. Does the fellow have access to appropriate imaging equipment to provide training in endoluminal procedures?
 ( ) YES ( ) NO

If no, please explain.

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| --- |
|  |

1. Does the fellow have an appropriate workspace that includes a computer? ( ) YES ( ) NO

If no, please explain.

|  |
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|  |

1. Does the fellow have access to on-line radiographic and laboratory reporting systems at the integrated sites?
 ( ) YES ( ) NO

If no, please explain.

|  |
| --- |
|  |

1. Does the fellow have access to adequate software resources for production of presentations, manuscripts and portfolios? ( ) YES ( ) NO

If no, please explain.

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|  |

## **Evaluation**

1. Describe how each fellow evaluates the program.

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| --- |
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2. Describe how the information from the evaluations is used in assessing the program’s effectiveness in achieving its educational goals.

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3. Describe how the teaching staff participates in the evaluation of the training program

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|   |

#  Participating Site Information

1. What is the total amount of time spent on rotations at non-integrated sites? ( ) Months

2. For all participating sites more than 30 miles from the sponsoring institution please indicate:

|  |  |  |
| --- | --- | --- |
|  | **1** | **2** |
| Do fellows commute to and from this site? [enter yes (Y) or no (N)] |  |  |
| If fellows **DO** commute, do they take overnight call? [enter yes (Y) or no (N)] |  |  |
| If fellows **DO NOT** commute, describe the living facilities. |
|  |

3. Provide the following information for each participating site [enter yes (Y) or no (N)]

|  |  |  |
| --- | --- | --- |
|  | **1** | **2** |
| Program director appoints members of the teaching faculty |  |  |
| Program director appoints the local Director |  |  |
| Program director determines all rotations and assignments for all fellows and members of the teaching faculty |  |  |
| Teaching conferences on site4 |  |  |

4If there is a training site with NO teaching conferences, please explain in the box below how the fellow participates in conferences and educational activities when assigned to that site (i.e. teleconference, return to primary training site, etc)

# Documentation of Faculty Scholarly Activity (Limit to 5 pages)

|  |  |
| --- | --- |
| **Name:** |  |
| **Principle hospital base:** |  |

**Current professional and academic appointments (include start date):**

|  |  |
| --- | --- |
| **Date of Appointment** | **Position** |
|  |  |
|  |  |
|  |  |

**A. Professional Education**

1. Undergraduate Medical Education (including dates and degrees):

|  |  |  |
| --- | --- | --- |
| **Dates of Attendance** | **Institution** | **Degree** |
|  |  |  |
|  |  |  |

(Insert additional rows as needed)

2. Postgraduate medical education (including dates of internships, residencies, fellowships, etc.):

|  |  |  |
| --- | --- | --- |
| **Dates of Training** | **Institution** | **Position** |
|  |  |  |
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(Insert additional rows as needed)

**B. Educational activities and recognition**

1. Teaching activities in the past year:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Conference/Activity** | **% Attended** | **Presented a Session\*** | **Directed a Session** | **Directed the Conference** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

\*also applies if supervised or mentored a presentation

2. Teaching awards (no time limit)

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| --- |
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3. Distinguished lectureships, visiting professorships (no time limit)

|  |
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|  |

**C. Leadership Activities** (in medical professional only. ONLY list activities since the last site visit)

1. School of Medicine (If just a committee member, DO NOT LIST)

|  |
| --- |
|  |

2. Hospital (If just a committee member, DO NOT LIST)

|  |
| --- |
|  |

3. Medical Societies (List offices held or positions of leadership. If just a member, DO NOT LIST)

1. Local

|  |
| --- |
|  |

1. Regional

|  |
| --- |
|  |

1. National

|  |
| --- |
|  |

1. International

|  |
| --- |
|  |

4. Professional Organizations (i.e. advisory councils, residency review committees, etc.)

|  |
| --- |
|  |

**D. Creative Activities** (since last site visit)

1. Basic Research (Insert additional rows as needed)

| **Project Name** | **Funding Source** |
| --- | --- |
| **Intramural** | **Extramural****(non-industry)** | **Industry** | **None** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

2. Clinical Research (Insert additional rows as needed)

| **Project Name** | **Funding Source** |
| --- | --- |
| **Intramural** | **Extramural****(non-industry)** | **Industry** | **None** |
|  |  |  |  |  |
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**E. Publications**

Please provide a list of your **most recent** publications and presentations (including specifics such as title, journal, date, etc.) **since last site visit. Divide into the following subcategories and do not list more than 10 in each subcategory:**

1. Peer-reviewed publications (i.e., journal articles)

|  |
| --- |
|  |

2. Other publications (i.e., non-peer-reviewed articles, book chapters, etc.)

|  |
| --- |
|  |

3. National/regional presentations

|  |
| --- |
|  |

When listing publications, do not include manuscripts that are in preparation or have been submitted but not yet accepted. Articles that have been accepted but not yet published should be listed as In Press and should include the name of the journal. It is not necessary to enclose a copy of the letter of acceptance with the application but this letter should be available for inspection by the site visitor..

# Block Diagram

Complete a block diagram for all types of VLM programs (independent and/or integrated at your institution. The block diagram MUST include the type of service (i.e., rotations through radiology, vascular surgery, and dermatology) and the site where the educational assignments occur. Provide a key for any abbreviations or acronyms used. Please note that all sites where fellows are assigned must be listed. Each year of the program must equal 12 months or 52 weeks. Indicate inpatient (I), outpatient (O), or I/O for both experiences.

Please fill out the block diagrams applicable to your current and/or proposed program format(s).

**VLM Fellowship *(example)***

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Period** | Mo1 | Mo2 | Mo3 | Mo4 | Mo5 | Mo6 | Mo7 | Mo8 | Mo9 | Mo10 | Mo11 | Mo12 |
| **Site** | Hosp | Office | Office | Office | Hosp | Office | Office | Office | Hosp | Office | Office | Office |
| **Service** | VS/RAD | PHL | PHL | DERM  | VS/RAD | PHL | PHL | PHL | VS/RAD | PHL | PHL | PHL |
| **Inpatient / Outpatient** | I/O | O | O | O | I/O | O | O | O | I/O | O | O | O |

**YOUR DATA (to be filled in):**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Period** | Mo1 | Mo2 | Mo3 | Mo4 | Mo5 | Mo6 | Mo7 | Mo8 | Mo9 | Mo10 | Mo11 | Mo12 |
| **Site** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Service** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Inpatient / Outpatient** |  |  |  |  |  |  |  |  |  |  |  |  |