THE UNIVERSITY OF ARIZONA
College of Medicine
Tucson

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REQUEST FOR PROGRAM COMPLEMENT CHANGE

DO NOT USE for programs requesting a temporary increase in complement to accommodate a resident leave of absence or for educational remediation

Program: _____

Core Program (if applicable):_____

Program Director: _____

Please answer the following:

1. What is the current approved complement for the program (by PGY-level, if applicable?)
2. What is the requested increase/decrease in the number of trainee(s)?
3. Is this a temporary or a permanent change request?
4. How will this change align with strategic priorities of Banner Health and the University of Arizona College of Medicine - Tucson?
5. How does this request align with the workforce needs (locally and/or nationally) for your specialty?
6. What is the program's current ACGME Accreditation status?
7. Does the program have any current ACGME Citations or Areas of Concern?
8. Will the program maintain compliance with program requirements for faculty/trainee ratios if this change is approved? Please explain.
9. Has this request been discussed with the program's Clinical Competency Committee or Program Evaluation Committee to ensure all program requirements will continue to be met with the requested change?
10. Discuss the impact, both clinically and educationally, of this change on current trainees in the program, as well as in any related programs.
11. What is the potential impact to the program if this request is NOT approved?
12. Does your program's RC have any specific forms, documents, or other requirements that must be included in the complement change request? (YES / NO) If YES, please attach.
13. Does your program participate in the NRMP Match, or any other Match program? If so, what is the quota change deadline for your program's participation in the Match?

14. What are the current FTE requirements for the Program Director (PD), Associate Program Director (APD), and Program Coordinator (PC) at your current complement? Will the complement change alter these ACGME minimum FTE requirements?

15. **If this is a request for a complement increase**, describe the source of funding for this request. Please include written documentation of the funding commitment for the complement increase AND any required additional PD/APD/PC FTE.

Program Director Name	Program Director Signature
Core Program Director Name (if applicable)	Core Program Director Signature
Department Chair Name	Department Chair Signature

Form Submitted by: _____

Date Submitted: _____