



REQUEST FORM for **NEW ACGME-ACCREDITED PROGRAM**

Date: _____

Program: _____

Program Director: _____

Please answer the following:

1. How will the new program align with strategic priorities of Banner Health and the University of Arizona College of Medicine – Tucson?
2. How does this request align with the workforce needs (locally and/or nationally) for your specialty?
3. Discuss the impact of the addition of this new program, both clinically and educationally, on any related programs.
4. What are the requested new program's FTE requirements for the Program Director (PD), Associate Program Director (APD) if applicable, and Program Coordinator (PC) for the requested resident complement?
5. Describe the source of sustained funding for this request. Please include written documentation of the funding commitment for the requested program's resident complement AND for the required PD/APD/PC FTE.

Program Director Name

Program Director Signature

Core Program Director Name

Core Program Director Signature

Department Chair Name

Department Chair Signature

Form Submitted by: _____

Date Submitted: _____