**Institution Tables**

Using the templates provided below, please provide the program’s institutional information that is pertinent to the program change.

1. **SPONSORING INSTITUTION: (Institution #1)** (The university, hospital, or foundation that has ultimate responsibility for this program and must be accredited as a sponsoring institution by the ACGME.)

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| Name of sponsor:       |
| Address:       |
| City:       | State:       | Zip code:       |
| Type of institution: (e.g., teaching hospital, general hospital, medical school):        |
| Ownership type: (e.g., state, corporation, church):       |
| Is the institution ACGME accredited [ ]  YES [ ]  NO  | Duration of accreditation:        | Next review date:       |
| Name and credentials of the designated institutional official:       |
| Does the **SPONSOR** have an affiliation with a medical school (may be the sponsoring institution)? | [ ]  YES  | [ ]  NO |
| If yes, name of medical school:       |

1. **PRIMARY INSTITUTION (Institution #2)**

[ ]  Same as the sponsoring institution

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| Name:       |
| Address:       |
| City:       | State:       | Zip code:       |
| Name and credentials of the individual responsible for oversight of training at this institution:       |

1. **PARTICIPATING INSTITUTION (Institution #3)**

[ ]  Not applicable

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| Name:       |
| Address:       |
| City:       | State:       | Zip code:       |
| Distance from primary institution  | Miles: |        | Minutes: |       |
| Type of rotation (select one) | Elective [ ]   | Required [ ]   | Both [ ]   |  |
| Duration of fellow’s rotation (in months) | Year 1: |       | Year 2: |       |  |
| Name and credentials of the individual responsible for oversight of training at this institution:       |
| Brief educational rationale for use of this institution:       |