Flexible Education Experience
in Obstetrics & Gynecology

Date submitted _____

The Letter of Agreement for a resident in Obstetrics and Gynecology to have an educational opportunity greater than six months and up to twelve months during their four-year ob-gyn training must include the following:

I. Dr. _____, a PGY-___ in the _____, ACGME approved ob-gyn residency program, will spend _____ months from _____, 200__ to _____, 200__ at _____ Institution. This educational experience will fall under the supervision of Dr. _____ at Institution _____ while the satisfactory completion of their residency training remains the resident's Program Director's responsibility.

II. If the Institution is different than the sponsoring Institution of the ACGME-approved ob-gyn residency program, a signed and dated Letter of Agreement documenting the agreement between both institutions must be attached.

III. A description of how the resident's salary, benefits, malpractice coverage, hospital privileges, and licensure will be ensured (attach).

IV. The justification of this resident's individualized educational experience (attach).

V. A description of how the ob-gyn residency program will be impacted by this resident's experience with clarification of how the work usually carried out by this resident will be performed and how the call rotation will be modified (attach).

VI. A description of the methods utilized by the ob-gyn residency program director to ensure that Dr. _____ will successfully complete the educational requirements of this individualized experience as well as completion of four years of residency training in obstetrics and gynecology (attach).

VII. ABOG approval of the application: ___ Yes ___ No ___ Pending

VIII. Signatures of Program Director and Supervising Physician and Resident:

_____ _____
Program Director Date

_____
ACGME-Approved Ob-Gyn Residency Program

_____ _____
Physician Supervising Resident's Individual Experience Date

_____
Name of ACGME approved Institution for Resident's Individual Experience

_____ _____
Designated Institutional Official's Signature Date

_____ _____
Resident Physician Date

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