NOSM University Postgraduate Resident Accommodation Plan

Date: _____

Resident Name	NOSM U ID #	Program	PGY Level
			PGY6

Dear _____,

Program Director

The NOSM U Postgraduate Medical Education Office is mandated to arrange accommodations for residents under compassionate grounds that can be implemented without compromising the academic integrity of the residency program.

_____ has provided appropriate documentation outlining their specific case to the Accessibility Advisor. The following accommodations are approved by the Accommodations Committee.

Accommodation Type	Description	Estimated Duration
Duty hours		
Leave		

Accommodation Type	Description	Estimated Duration
Clinical Tasks		
Non-Clinical Tasks		
Academic sessions		
Written assessments		
Oral assessments		
Housing		

Accommodation Type	Description	Estimated Duration
Transportation		
Other		

Adapting a training program while upholding its academic integrity and continuous service to patients can be challenging. The Postgraduate Medical Education Wellness Program and Learner Support Services are available to support you and your Residency Program Committee as required.

If you cannot operationalize any of the above, please notify the Postgraduate Medical Education Wellness Program promptly.

The involvement of _____ with the Postgraduate Education Wellness Program and the requirement for accommodations is confidential. It must not be identified on any transcript, evaluation, or official record. Accommodations can be shared with supervisors and administrators only on a need-to-know basis and/or with the express consent of the resident.

Thank you for your attention to these matters and your support for the well-being of

_____

Yours sincerely,

_____ _____

Dr. Sean Sullivan, MD CCFP
Assistant Dean of Resident Affairs
Resident Wellness Program,
Postgraduate Medical Education

Date Signed

I have reviewed and understand the accommodations parameters required.

_____ _____

PGME Resident, _____ Date Signed

I have reviewed and understand the accommodations parameters required.

_____ _____

Program Director, _____ Date Signed

CC: _____

CC: _____

CC: _____

DO NOT REMOVE THIS VERSION RECORD FROM THIS DOCUMENT		
Version	**Date**	**Authors/Comments**