



TAGME

2008 Application Forms

- Application Form
- Curriculum Vitae Template
- Supportive Verification Form
- Registration Form



2008
APPLICATION FORM
National Board of Certification
Training Administrators of Graduate Medical Education

Applicant Name: _____

Applicant Title: _____

Clinical Specialty: _____

Program Name: _____

Program Address: _____

Program Phone: _____

Email: _____

Application dates: **March 1 – May 30** for assessment sites between July 1- December 31
 September 1 – November 30 for assessment sites between January 1 – June 30

I have enclosed:

- This completed application form
- Application CV using the standard format ONLY (please see example)
- The Criteria for Application is as follows:**
- **3 years as coordinator of _____ (insert clinical specialty)**
 - **attendance at one national meeting in the past 3 years, whose focus is graduate medical education**
 - **participation in a site visit or internal review within the past 3 years**
 - **personal professional development within the past 3 years – presentations at national, state, institutional or departmental level; poster presentations or manuscripts published**
- Supportive Verification Form completed and signed, sealed in program envelope with signature of verifier across the back flap.
- A certified check, personal check, or money order, or a program, institution or department check, payable to TAGME for the application and assessment fees.
- \$250.00 for the initial certification
 - \$125.00 for recertification
 - \$125.00 for additional specialty/subspecialty certification. Note: 1) candidate must have successfully completed initial certification for Global and a Clinical Specialty's Tools; and 2) must have current/active certification status through TAGME.
- Need for Special Accommodations; see Special Accommodations Guidelines on page 5

Your name as it should appear on your certificate: _____

OPTIONAL- if you would like your Program Director, Department Chair, or Designated Institutional Official (DIO) to receive a copy of your receipt of certification letter, please provide contact information below:

Program Director Name/Address:

Department Chair Name/Address:

DIO Name/Address:

By signing this form, I understand that:

1. Upon receipt and review of the above documents, I will receive notice of the status of my application and eligibility for certification by email. Pending eligibility, I will have one year to complete all assessments tools. All submitted documentation will be held for one year from date of receipt. At that time it will be destroyed. No application materials will be returned. My original application CV will be kept on file, along with the tracking of my progress.
2. It is the responsibility of the applicant to see that the Board has received all the required documentation. Applicants who do not submit the required documentation will not qualify for certification.
3. The candidate who provides false information on their application will lose all rights to certification.
4. The duration of certification is 5 years at which time renewal will be required.

Signature:

Date:



APPLICATION – CURRICULUM VITAE

National Board of Certification
Training Administrators of Graduate Medical Education

DIRECTIONS:

Please create your certification CV using the following format, copying and substituting your information. Only record the previous 3 years for all areas except employment. Delete this direction statement.

Name: *Susie Smith*

Title: *Program Coordinator*

Clinical Specialty: *Internal Medicine*

Program/ GME Name: *Some Place Internal Medicine Residency Program*

Program/ GME Address: *Some Place Medical Center – 123 Some Street – Some Place, Some State, Some Zip*

Program Phone: *(000) 444-4444* **Fax:** *(000) 444-4445*

Email Address: *inacordinator@someplace.edu*

Program/GME Director: *U.R. Mypd, MD*

Sponsoring Institution: *University of Some Place*

Home Address: *123 Live Here, Some Place, Some State, Some Zip*

EMPLOYMENT:

1/ 2000 – Present **Program Coordinator; Some Place Internal Medicine Residency Program**

PROGRAM REVIEWS FOR ACCREDITATION:

3/2003 RRC Site Visit – Some Place Internal Medicine Residency Program - Accreditation status pending

3/2001 Internal Review – Some Place Internal Medicine Residency Program

MEETING ATTENDANCE:

5/2004 – Association of Internal Medicine Residency Coordinators Spring Conference; Orlando, Florida.

3/2003 – ACGME Educational Workshop; Chicago, Illinois.

PERSONAL PROFESSIONAL GROWTH EXPERIENCES:

Publications: Referred; Peer-Reviewed; Invited

UR Mypd, MD; S Smith; “How My Residency Works”; GMEJournal; May, 2002; 35.

PRESENTATIONS OR POSTERS:

Association of Internal Medicine Residency Coordinators; “Why Did I Choose This Job?”; Orlando, Florida; May 2004.

Professional Organizations; Committee Membership; Leadership Roles where appropriate:

Association of Internal Medicine Residency Coordinators Steering Committee; 2002-2004

Association for Internal Medicine Education; 2000-Present

University of Some Place GMEC Committee; 2003-Present

University of Some Place Coordinator Education Forum Committee; 2000 – Present;

Chair – 2003-Present

Planning Committee – 2001-2003

EDUCATION: (highest degree awarded)

(Examples):

High School Diploma

College: *BS in Education*



APPLICATION - SUPPORTIVE VERIFICATION FORM

**National Board of Certification
Training Administrators of Graduate Medical Education**

PLEASE TYPE OR PRINT:

Applicant:

Clinical Specialty:

Training Program:

Address of Training Program:

MAILING INSTRUCTIONS: Place your completed and signed form in a program envelope, seal it and write your name across the back flap. Return it to your training administrator. This is a required document to be included in the application for certification. The purpose of this form is to verify the criteria for certification.

My professional relationship to the applicant is (please check one):

- Chair
- Program Director
- Assistant/Associate Program Director
- DIO

_____ (applicant) is submitting an application to be a Certified Training Administrator for Graduate Medical Education Programs, with added qualifications in _____ (clinical specialty). Please verify the following:

1. The applicant has been an administrator for this training program for at least three years.
____ Yes ____ No
2. The applicant has participated in at least one internal review and/or one Institutional or RRC site visit in the last three years.
____ Yes ____ No
3. The applicant attended at least one national conference in the past three years, whose focus was graduate medical education.
____ Yes ____ No
4. The applicant has participated in at least one of the following opportunities for personal professional growth within the past three years: presented at a national, state, regional or departmental conference; manuscript publication; poster presentation at a national, state, regional or departmental conference; leadership role in an activity and/or committee of the sponsoring institution.
____ Yes ____ No
5. The applicant has sufficient skills, knowledge and abilities to manage the day-to-day responsibilities and activities of the training program. These skills may include some of those listed below as they apply to your program.
____ Yes ____ No

SKILL SET

- Communication
- Excellent Verbal Skills
- Excellent Written Skills (brochures, policy manuals, minutes, memos, newsletters, documentation for ACGME (site visits), ABMS, etc.)
- Technical – computer and database management
- Research and data analysis skills
- Excellent problem solving and decision-making skills
- Demonstrated mastery in supervision and development of support personnel
- Demonstrated knowledge of Human Resources issues and policies
- Demonstrated knowledge of institutional and departmental policies and procedures
- Demonstrated mastery in program development, program administration and policy implementation
- Demonstrated knowledge of various regulatory bodies, (e.g., ACGME, ABP, etc.).
- Skills in coordinating multiple, simultaneous ongoing program demands
- Knowledgeable in preparation, allocation, and fiscal management of house officer budgets
- Organizational expertise, attention to detail, dependability and trustworthiness
- Adept at time management and self motivation

ATTITUDES

- Effectively communicates with others
- Ability to work collaboratively and effectively with other departments and outside agencies
- Fosters teamwork with residents, medical students, faculty and professional associates
- Responsive to the needs of others

PROFESSIONALISM

- Exhibits personal excellence in leadership and management
- Creates and supports an environment that fosters teamwork, cooperation, respect and diversity
- Respects the inherent worth of all individuals evidenced through inclusiveness and diversity
- Commitment to carrying out professional responsibilities
- Adheres to strict ethical principles
- Analyzes and synthesizes information well
- Makes informed decisions
- Recognizes limits of knowledge and expertise, and seeks help appropriately
- Utilizes cost-effective approach to office management
- Demonstrates a willingness to learn from others
- Maintains confidentiality in all aspects of job duties (personnel files, evaluations, Interviews, etc.)
- Promotes positive change and innovation, constantly seeks ways to improve

6. Please comment on the effort made and/or the impact of the applicant on the training program. Attach additional pages as needed. (This question is optional.)

Print Name:

Signature:

Date:



2008 REGISTRATION FORM
FOR THE FALL OPEN MONITORED ASSESSMENT SITES
***** IMPORTANT *** This Form Must Accompany Your Application Materials**

Please Print:

Name: _____ Last 6 digits of Social Security Number: _____

Work Address: _____

City: _____ State _____ Zip _____

Clinical Specialty: _____

Applicant's Signature: _____

Please register me for the 2008 TAGME Open Monitored Assessment Site indicated below. I understand that my application and registration materials must be received by TAGME, postmarked on or before June 6, 2008. I also understand that I will receive instructions regarding required appropriate measurement / assessment information upon receipt of this form.

- _____ Advocate Lutheran General Hospital, Chicago, Illinois
 _____ Case Western School of Medicine, Cleveland, Ohio
 _____ EKLMC Medical Center, Baton Rouge, Louisiana
 _____ Emory University, Atlanta, Georgia
 _____ Indiana University School of Medicine, Indianapolis, Indiana
 _____ Mayo School of Graduate Medical Education, Rochester, Minnesota
 _____ University of Miami, Miami, Florida
 _____ University of Michigan, Ann Arbor, Michigan
 _____ University of South Carolina, Columbia, South Carolina
 _____ University of Texas Health Center-San Antonio, San Antonio, Texas
 _____ University of Wisconsin, Madison, Wisconsin
 _____ Vanderbilt, Nashville, Tennessee
 _____ West Virginia University, Charleston, West Virginia

I will be sitting for:

- _____ Initial certification: Global and Clinical Specialty Monitored Assessment Tools
 _____ Retake – Global and Clinical Specialty Monitored Assessment Tools
 _____ Retake – Global Monitored Assessment Tool
 _____ Retake – Clinical Specialty Monitored Assessment Tool

Please return to: Ellen Greenberger, C-TAGMe
 Department of Orthopaedics
 11100 Euclid Avenue
 HH 5043
 Cleveland, Ohio 44106
 Email: resicoordinator@tagme.biz