Resident Remediation Plan

**Date of Remediation Plan Meeting:**

**Name of Resident:**

**Primary Supervisor/Advisor:**

**Names of All Persons Present at the Meeting:**

**All Additional Pertinent Supervisors/Faculty:**

**Date for Follow-up Meeting(s):**

Circle all competency domains in which the trainee’s performance does not meet the benchmark: Patient Care, Medical Knowledge, Practiced Based Learning and Improvement, Professionalism, Systems Based Practice, Interpersonal and Communication Skills.

Specific Areas for Growth:

Description of the problem(s) in each competency domain circled above:

Date(s) the problem(s) was brought to the trainee’s attention and by whom:

Steps already taken by the trainee to rectify the problem(s) that was identified:

Steps already taken by the supervisor(s)/faculty to address the problem(s):

Remediation Plan

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| --- | --- | --- | --- |
| **Competency Domain/****Essential Components** | **Problem****Behaviors** | **Expectations for Acceptable Performance**  | **Trainee’s Responsibilities/****Actions**  |
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Additional Responsibility:

Timeframe for acceptable performance:

Assessment methods:

Dates of the evaluation:

Consequences for unsuccessful remediation:I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed the above remediation plan with the residency training faculty, any additional supervisors/faculty, and the director of training. My signature below indicates that I fully understand the above. I agree/disagree with the above decision (please circle one). My comments, if any, are below (*PLEASE NOTE: If resident disagrees, comments, including a detailed description of the resdient’s rationale for disagreement, are REQUIRED).*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trainee Name Date Training Director Date

Resident’s comments (Feel free to use additional pages):

All supervisors/ faculty with responsibilities or actions described in the above remediation plan agree to participate in the plan as outlined above. Please sign and date below to indicate your agreement with the plan.

Remediation Plan Continued

SUMMATIVE EVALUATION OF REMEDIATION PLAN

Follow-up Meeting(s):

Date (s):

In Attendance:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Competency Domain/****Essential Components** | **Expectations for Acceptable Performance** | **Outcomes Related to Expected Benchmarks****(met, partially met, not met)** | **Next Steps****(e.g., remediation concluded, remediation continued and plan modified, next stage in Due Process Procedures)** | **Next Evaluation Date (if needed)** |
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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed the above summative evaluation of my remediation plan with my primary supervisor(s)/faculty, any additional supervisors/faculty, and the director of training. My signature below indicates that I fully understand the above. I agree/disagree with the above outcome assessments and next steps (please circle one). My comments, if any, are below. (*PLEASE NOTE: If resident disagrees with the outcomes and next steps, comments, including a detailed description of the resident’s rationale for disagreement, are REQUIRED).*

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Resident Date Training Director Date

Resident’s comments (Feel free to use additional pages):

**Algorithm for Reporting Difficulties**

|  |  |
| --- | --- |
| **Clinic/Rotation**Faculty SupervisorDrs. XYZ | **Hospital**Upper level residentAttending FacultyDrs. XYZ |

|  |
| --- |
| **Residency**Chief Resident(s) IREP Advisor Drs. XYZ |