MEDICAL CENTER HEALTH SYSTEM

PHARMACY RESIDENT HANDBOOK

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Pharmacy Clinical Coordinator & Pharmacy Practice PGY1 Residency Program Director:

Ashley Bane PharmD, BCPS

Emergency Medicine PGY2 Residency Program Director:

Laura Branum PharmD, BCEMP

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Medical Center Health System Introduction

I. Medical Center Health System (MCHS)

Medical Center Hospital has proudly served Ector County and the surrounding 17 counties of the Permian Basin since 1949. We've come a long way since we opened our doors, growing from a small county hospital into a prosperous 402-bed regional medical center; a teaching hospital; and now a health care system including satellite outpatient services and integrated physician services serving over 100,000 patients annually. We are still the only Level 2 Trauma Center and full-service hospital in the region, and we strive to deliver the best care possible for the people of the Permian Basin. Some services offered include: Bariatric care, Oncology, Cardiology, Diabetes management, Emergency department, Radiology, inpatient Rehab, Orthopedic/Surgery Care, Pediatrics, Respiratory Therapy, Sports medicine, Stroke Center, Trauma service, and Outpatient clinics.

II. MCHS Pharmacy Mission Vision Values

A. Hospital Mission:

a. Medical Center Health System is a community-based, teaching organization dedicated to providing high quality and affordable healthcare to improve the health and wellness of all residents of the Permian Basin.

B. Pharmacy Mission:

a. Medical Center Health System Pharmacy is committed to improving the well-being of our patients with medication, education, and collaboration.

C. Hospital Vision:

a. MCHS will be the premier source for health and wellness.

D. Pharmacy Vision:

a. To better the lives of the Permian Basin

E. Values "I CARE":

a. Integrity: to do the right thing when no one else is looking
b. Customer Centered: making our consumers the focus of everything we do
c. Accountability: to be responsible and follow through
d. Respect: to treat everyone how you would like to be treated
e. Excellence: always striving to do better

F. Pharmacy services:

a. The MCH Pharmacy exists to ensure safe, effective, and affordable medication use in our communities, one person at a time. The Pharmacy Team strives to provide optimal medication management across all dimensions of care, every time.
b. Pharmacy Services, working in concert with other hospital staff and medical staff, provides the following scope of services and care 24/7:
    a. Space, equipment, and supplies shall be provided to accommodate the professional and administrative functions of the pharmaceutical service as required to promote patient safety through the proper storage preparation dispensing and administration of drugs.

b. The necessary equipment for the compounding, dispensing, and manufacturing of pharmaceutical and parenteral preparations.

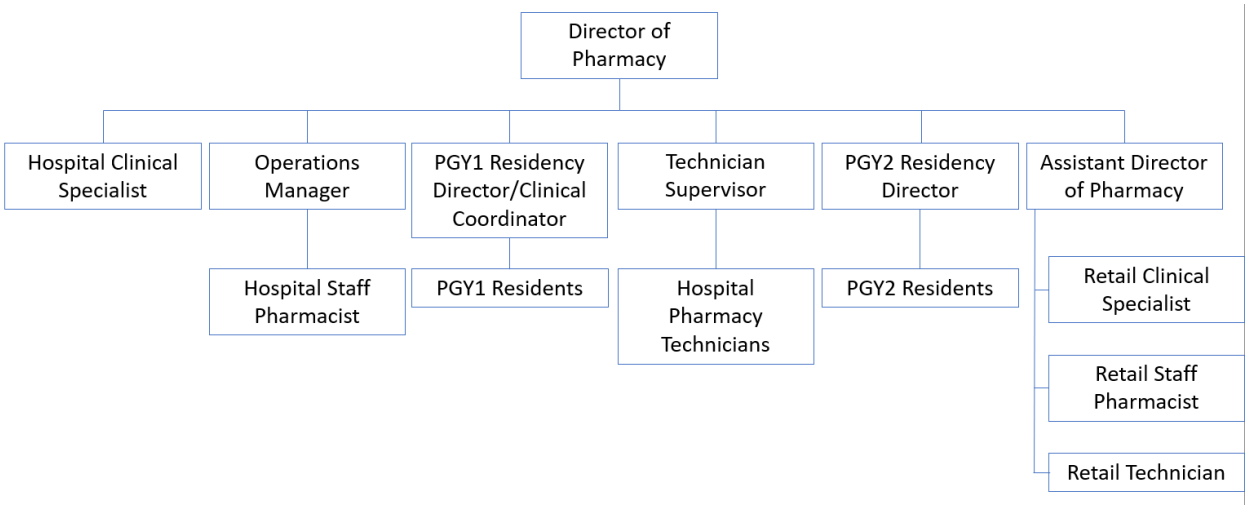
c. An adequate library to meet all State Board of Pharmacy requirements and needed information readily available to all pharmacists, physicians, and nurses.
d. Automation supplies and related materials and equipment necessary for the proper administration of the department
e. Designated areas and controls which meet the physical and legal requirements for the storage of controlled substances, alcohol, other legend prescription medications, and hazardous supplies as needed
f. Refrigerators/Freezers for the storage of thermo-labile products
g. Adequate floor space for all pharmacy operations in a suitable location, provided with proper lighting, ventilation, and security
h. Adequate access to computers and online databases, including: Drug reference databases, and search engines
i. The development of written policies and procedures
    a. Which pertains to the intra-hospital medication distribution system in cooperation with medical staff.
    b. Which governs the safe administration of medications and biologicals developed jointly with the medical staff, nursing service, and other related disciplines as necessary.
    c. Which guide medication use within recommended guidelines and best practices.
j. Medication monitoring services in keeping with each patient's needs which may include, but not be limited to the following:
    a. The maintenance of a computerized medication profile for each patient based on available medication history and current therapy, and shall include patient diagnosis, allergies, and/or sensitivities
    b. An on-going review of the patient's medication regimen for any potential interactions or incompatibilities prior to the dispensing of new medications to the patient
    c. The resolution of medication problems with the prescribing practitioner and, where appropriate, the notification of the nursing service and/or administration
    d. Instructions to the patient and/or appropriate nursing personnel who advise the patient on the importance and correct use of medications to be taken following discharge from the hospital. Such instructions shall be only at the request of the responsible practitioner or as provided by written medical staff policy or as mandated by federal or state regulations.
    e. Evaluation of non-formulary medication orders
k. The unit dose system for drug distribution.
l. A USP compliant IV admixture service, including hazardous substances (e.g., chemotherapy).
m. Provide services, drug information, and in-services to other healthcare professionals.
    a. Round with Texas Tech Internal Medicine and Family Practice teams, Trauma, Critical Care, and NICU teams as pharmacotherapy resources and provide drug

therapy evaluations and recommendations to optimize medication management

b. Maintain an accredited pharmacy residency program
c. Develop, precept and maintain objective based rotations for pharmacy interns, externs, and residents

n. Assist in rapid responses and code blues in the hospital as a part of the Code Blue team
o. Provide 24-hour ED pharmacy services which include drug information, expedited medication retrieval, and documentation of patients' medication histories
p. Maintain an antimicrobial stewardship program with an infectious disease physician in conjunction with Antimicrobial Stewardship Committee and Infection Control to oversee patient's antimicrobial therapy
q. Review electronic admission and discharge medication reconciliation to optimize medication management for patient
r. Assist in patient assistance by solving medication barriers to discharge for transitions of care
s. Provide assistance with obtaining medication upon discharge by designating a pharmacy technician to assist in the process for the patient assistance programs and the Medical Center Specialty Outreach Pharmacy (MCSOP).
t. Deliver medications (oral and IV meds, TPNs, continuous and intermittent IV fluids, IV piggybacks, etc.) to patient care areas
u. Monitor, maintain, and manage inventory of automated dispensing machines (ADM).
v. Provide a pharmacy technician trained to assist with medication delivery to operating room (OR) and have a pharmacist available for immediate consultation as needed
w. Re-label patient's hospital medications for discharge in compliance with Multidose Medication Dispensing at Discharge policy
x. Coordinate and support P&T committee activities which include, but are not limited to: developing, reviewing, and monitoring medication and therapy related policies (formulary, therapeutic interchange, high risk, SALAD, etc.), medication error reporting, quality monitoring reports, and drug shortage management.
y. Provide all Medical Staff approved protocol services (IV to PO conversion, pharmacokinetic dosing, renal dosing adjustments, pharmacy consults, etc.)
z. Maintain and monitor drug inventory
    a. Provide drug shortage information and management
    b. Evaluate formulary costs and savings opportunities
    c. Obtain, and monitor non-formulary medications

G. Pharmacy Organizational Chart:



III. MCHS PGY1 and PGY2 Pharmacy Residency Programs

A. ASHP Accreditation Standard for Postgraduate Year One (PGY-1) Residency and Postgraduate Year Two (PGY2) Pharmacy Residency Programs
   i. https://www.ashp.org/-/media/assets/professional-development/residencies/docs/examples/ASHP-Accreditation-Standard-for-Postgraduate-Residency-Programs.pdf

B. Residency Advisory Committee (RAC)
   i. The Residency Advisory Committee exists to ensure the program is functioning well within standards and being optimized as appropriate. The committee assesses resident progress and, if needed, will be used to efficiently address resident issues and initiate disciplinary action when necessary.
   ii. RAC will be made up of all residency preceptors.
      1. Decisions will be decided by majority vote
      2. To have a quorum for disciplinary action there will need to be at least 10 RAC members present
   iii. RAC meets at least every other month to discuss the residency program, resident progress, concerns, improvement plans, and to assess resident progress through the residency and feasibility to successfully complete the residency.
   iv. Residents are invited to every other meeting and are required to attend the first half of the meeting. Residents are excused for the second half of the meeting for the preceptors to discuss residents' progress and make suggestions for a development plan.
   v. Quarterly, residents will meet with a smaller group of preceptors (past rotation, current rotation, future rotation) and the residency director to discuss:
      1. Whether the resident is on track to complete the residency
      2. Progress reports: what the resident is doing well and where they need to improve
      3. Plan to ensure the resident can complete the residency

4. Graduation checklist/assignments/deadlines
5. This will be a time for mentorship/coaching

vi. Special RAC committee will be called to discuss disciplinary and employment decisions.

C. Preceptors

Adewale Balogun, PharmD, BCPS	Staffing, Internal Medicine
Ashley Bane, PharmD, BCPS	Trauma, Pharmacy Administration
Michele Bender, PharmD, BCEMP	Emergency Medicine – Night Shift
Laura Branum, PharmD, BCEMP	Emergency Medicine – Day Shift
Brandon Buss, PharmD	Critical Care
Kristina Chang, PharmD, BCCCP	Emergency Medicine – Day Shift, Trauma
Charlie, Cid, PharmD	Internal Medicine
Carrolyn Cowey, PharmD	Emergency Medicine – Night Shift
Cheryl Go, PharmD	Staffing, Internal Medicine
Alex Green, PharmD	Staffing
Yaze Li, PharmD, MBA	Pharmacy Administration
Mary Kim, PharmD	Transitions of Care
Arturo Munoz, PharmD	Neonatal Intensive Care
James Palmer, PharmD, BCCCP	Pharmacy Operations, Medication Safety
Kayla Rhodes	Internal Medicine
Alexander Rothenberger, PharmD, BCPS	Critical Care, Antimicrobial Stewardship
Thao-Mi Vu, PharmD	Critical Care
Erica Wilson, PharmD, BCPS	Pharmacy Administration, Pharmacy Operations,

D. Application, Selection and Qualifications of Residents

i. Residents must have a Doctor of Pharmacy (PharmD) degree from an American Council of Pharmaceutical Education (ACPE) accredited pharmacy school or an equivalent degree.

ii. Any applications completed after the deadline are automatically disqualified from the selection process. A peer interview group selects qualified candidates for the virtual interview. This committee also decides the final ranking to be submitted to the match system.

iii. A qualified resident should be in good academic standing, demonstrate excellent communication, time management, customer service, and critical thinking skills.

E. Compensation and Benefits

iv. Salary (PGY1 Pharmacy Residents) paid biweekly

v. Salary (PGY2 Emergency Medicine Residents) paid biweekly

vi. Health benefits: full health benefits that include medical, dental, and vision options (selection of plans will occur on arrival).

vii. Professional leave for PGY1 Pharmacy Residents: 10 paid professional leave days will be provided which will include leave for required conferences
viii. Paid personal leave (PPL):
    a. Traditional and Non-traditional PGY1 Pharmacy Residents and PGY2 Emergency medicine Residents: accumulate PPL according to policy MCH-3000.
        a. Exclusions: mandated employee health sick leave in which resident can work from home, PPL bank hours will not have to be used, this plan must be approved by RPD
    b. All PPL must be pre-approved by the Pharmacy Residency Director and must follow the PHM-0203 pharmacy PPL request policy.
        a. Weekends are not eligible for PPL, must trade with another resident or another staff member, if trade is with another staff member this must be approved by RPD
        b. (From PHM-0203): Requests for time off will be submitted by 5pm on the 15th of each month for the next schedule release (i.e., PPL requests for February should be submitted by 5pm on December 15th). This will be a minimum of 45 days in advance of the first day of the month containing the requested days off. This will allow adequate time for schedule preparation to meet the maximum number of requests possible and the employee adequate time to reschedule plans for days the schedule will not accommodate.
ix. Attendance & Punctuality
    a. Will follow learning experience specific punctuality
        a. Ex: ED start time is 10:00 cannot be late
    b. If learning experience or preceptor does not designate specific punctuality, will follow pharmacy and hospital policy as per pharmacy handbook

x. Licensure

    a. It is preferred that the Texas Pharmacy Licensure exams are completed prior to the start of the residency program.
    b. If Texas Pharmacist Licensure is not obtained prior to the start of the residency, a valid Texas Pharmacy Intern License must be obtained prior to starting the residency program (forms are available on-line at http://www.tsbp.state.tx.us). If licensure is not obtained within 120 days of the start date of the residency year, the resident will be subject to dismissal from the residency program. If there are extenuating circumstances outside of the resident's control preventing completion of licensure requirements, these situations will be considered on a case-by-case basis.
        a. If not licensed within 90 days emergency RAC session may be called also residents may opt to be suspended from the

program without pay and benefits to aide in studying. The resident will be reinstated and pay and benefits will resume when pharmacist licensure is obtained. The end date of the residency program will be extended by the number of days of suspension from the program. Extension of the program will include benefits and salary. If the resident is not licensed within the 120 days of the start of the program, the resident will be dismissed from the program and employment will be terminated.

xi. Orientation: Resident will be trained in various areas of pharmacy operation during the residents' first 5-weeks of employment through observation, direct instruction, hand-on practices, classroom lectures, etc.

xii. Holiday commitment: residents are expected to work on all holidays that occur during their normal working hours. PPL may be used for holidays but must follow the PPL approval process.

xiii. Extended Leave: under extenuating circumstances, as determined by pharmacy management and the Residency Program Director, the resident may be allowed to complete any outstanding days off in excess of their allotted PPL in the program after the end date for the residency year on a voluntary basis without pay in order to complete the program and be awarded a certificate of completion.

    a. Time away from the residency program cannot exceed a combined total for greater than 37 days.
        a. If there are extenuating circumstances when a resident needs more than 37 days away from the program, they will discuss with RPD and Director of Pharmacy these situations and be considered case-by-case.

xiv. Dress code (in addition to employee dress code policy MCH-1027)

    a. All employees are required to wear their photo-identification badge provided by the hospital while on duty. Badges are to be worn above the waist.
    b. For clinical departments, a closed toe shoe is required
    c. Scrubs may be worn when approved by preceptor
        a. Pharmacy Department scrub color is Galaxy Blue
    d. If an employee is not required to wear a uniform or lab coat, neat, clean, pressed clothing must be worn
        a. The following must be professional in appearance and appropriate for the job duties of the employee:
            a. Skirt or dress length must touch the top of the knee cap.
            b. Slits in skirts/dresses (must be modest)
            c. Appropriate denim clothing (no Jeans) unless allowed by MCH executive team
            d. MCHS approved team T-shirts are allowed to be worn

e. Due to patients and employees having allergies/breathing issues residents should not wear strong smelling perfume/deodorant/lotion.
f. Residents are expected to adhere to employee hygiene standards, including but not limited to: clean and neat appearance of own person as well as clothing, appearing well-groomed and utilizing appropriate personal hygiene

F. Residency Requirements

i. Time commitment
    1. PGY1 Traditional Pharmacy Residents: 52 weeks
    2. PGY1 Non-Traditional Residents: 104 weeks
        a. 52 weeks on learning experiences as a resident
        b. 52 weeks of staffing
    3. PGY2 Emergency Medicine Residents: 52 weeks
ii. Duty-Hour Requirements: https://www.ashp.org/-/media/assets/professional-development/residencies/docs/duty-hour-requirements.ashx
iii. Moonlighting: only internal moonlighting permitted
    1. Max of additional 20 hours allowed per pay period
iv. Resident may be scheduled to cover shifts while on rotation if the following are met:
    1. Preceptor in area needing coverage that has previously had the resident states that resident can cover majority of the service independently (consults, order verification, profile review, physician and nursing communication)
    2. Maximum number of times a resident can cover a shift outside of their rotation without a primary preceptor is 3/month (exclusions: the rotation resident is currently scheduled on, PRN shifts picked up by resident outside of regular hours)
    3. If the resident is without a primary preceptor >/= 5 times during a rotation, excluding in-rotation coverage core rotations may be extended and elective rotations adjusted as needed to complete rotation (exception: transitions of care rotation)
v. Self-responsibility
    1. Residents should solicit constructive verbal and documented feedback from preceptors on individual tasks or activities and rotation progress.
    2. Self-reflection and accurate self-assessment are keys to success in the residency program.
    3. Residents need to accept responsibility for actions and performance.
    4. It is crucial to understand that constructive criticism will be given in order to succeed and grow throughout the program.

5. The ability to accept this feedback and make appropriate changes and improvements in performance will determine residents' progress throughout the year.

vi. Satisfactory Completion of Rotations
    1. Resident has not missed more than 5 days in a single rotational month without make up days
    2. Appropriate progression/improvement of resident through learning objectives as evaluated by preceptor
    3. Any areas for Needs Improvement in PharmAcademic should be discussed by the preceptor at the next RAC meeting, and written evaluations must include ways to improve performance in future rotations.
    4. Competency Scores will be assessed and used to identify residents that are failing to progress appropriately through clinical pharmacist skills
    5. Completion of rotation or failure of rotation is assessed by the objectives of the rotation, or competency checklist score
        a. During midpoint evaluation, if the preceptor is concerned for a potential failure this will be discussed with RPD immediately
        b. The preceptor, RPD, and resident will meet to discuss issues with performance, and decide on a course of correction, which may include:
            i. Plan is developed with clear goals and expectations to help resident pass the rotation in time remaining
            ii. If resident fails a core rotation
                1. Will repeat the core rotation → will lose an elective rotation and will repeat the core when the elective was scheduled
                2. Repeat another core that covers what the resident struggled on → will lose an elective rotation and will repeat the other core rotation when the elective was scheduled
            iii. If resident fails an elective rotation
                1. Repeat the elective rotation in place of another rotation
                2. Do not repeat elective rotation and continue with current elective choices
    6. If a resident fails a rotation according to competency scores, failure to meet defined expectations or objectives in PharmAcademic syllabus or other policy violations, this will be discussed with RPD and at the next RAC meeting.
        a. The preceptor, RPD, and resident will meet to discuss issues with performance, and decide on a course of correction, which may include

i. Repeat of the rotation (can only repeat the same rotation one time throughout residency)

7. Residents must complete all evaluations within 7 days of rotation completion but ideally during the last week of rotation prior to the final evaluation.
    a. If this is not maintained, discussion with the RPD will occur and may include coaching and counseling or disciplinary action for not meeting job requirements according to HR policies.
    b. If after discussion with RPD and no change emergency RAC may be held.

vii. Disciplinary Action and Dismissal from Residency Program

1. Emergency Special RAC committee will be called when:
    a. Resident is not licensed within 90 days
    b. Resident is not progressing per residency objectives and/or competency evaluation
        i. 6 or greater Needs Improvements by the end of December
        ii. <15 Achieves for residency by end of March
    c. Graduation checklist
        i. Less than 25% completed by December
        ii. Less than 50 % completed by March
    d. Multiple missed Major Project deadlines with concern for:
        i. Being able to present a completed Major Project at a local/state meeting
        ii. Being able to complete a publishable Major Project manuscript
    e. Resident fails 2 or more rotations
    f. Other problem areas of concerns
    g. The decision at emergency RAC will be
        i. Further corrective action as determined by committee and/or HR
        ii. Termination of residency
2. Preceptor Disciplinary Action Procedure
    a. Preceptors will keep track of problem areas or concerns pertaining to the resident in an excel sheet that will be shared with the resident and at RAC.
    b. If there are numerous corrections and guidance from the same complaint RPD will discuss with the resident and some preceptors
        i. Emergency RAC can be called if correction within the designated time frame does not occur.
    c. Exemptions to above hierarchy of discipline:
        i. Resident intentionally acts with intent to harm or deceive.

ii. The event involves impairment of clinical activity
iii. Missed days/No call no show as according to hospital policy
iv. Resident who willfully continues behavior after receiving education or fails to participate in the education or other preventive plan.
v. Committing plagiarism as determined by RAC after review of the materials suspected of plagiarism.

d. Dismissal will follow MCH Hospital Policies and Procedures

3. Residency Remediation/Disciplinary Policy
    a. Residents are expected to complete all requirements of the Residency Program based on the ASHP Residency Standards and Competency Areas, Goals and Objectives for their specific program. Only those residents who complete the residency requirements set forth will receive their residency certificate. Evaluation of the resident's progress in completing the residency completion requirements is documented as part of the quarterly review process.
    b. The residency program director (RPD), in conjunction with residency advisory committee (RAC), will continually assess the ability of the resident to meet the residency requirements by established deadlines. If a resident is failing to make progress in any aspect specific to the residency program completion requirements (e.g., “Needs Improvement” (NI) for the same objective on more than one summative evaluation, multiple NI’s for a single summative evaluation, not meeting progression expectations during a learning experience, not meeting deadlines), or if there is a concern with other behaviors related to performance (e.g., unprofessional behavior, plagiarism) the following steps shall be taken.
        i. The RPD will provide the resident verbal coaching for any initial issues identified. If the identified issues continue, the resident will be placed in a resident corrective action plan. The plan will provide specific action steps to address the behavior or performance concerns. The plan will indicate the criteria for successful remediation.
            1. If the resident meets the criteria for successful remediation, the resident must not regress for the duration of the residency to receive a certificate of completion.
            2. If the resident is not successful in completing the action steps, yet makes progress, a second

resident corrective action plan can be executed as decided by RAC.

3. If the resident does not meet the criteria for successful remediation in the first or second plan, the resident will be dismissed from the program and will not receive a certificate as decided by RAC.

c. If a resident completes 52 weeks of the residency but does not fulfill all residency completion requirements, a certificate will not be issued.

4. Exemptions to above hierarchy of discipline:
    a. Resident intentionally acts with intent to harm or deceive.
    b. The event involves impairment of clinical activity
    c. Missed days/No call no show as according to hospital policy
    d. Committing plagiarism as determined by RAC after review of the materials suspected of plagiarism.
5. Dismissal will follow MCH Hospital Policies and Procedures

B. Resident Training Guidelines
    i. Purpose: to promote resident critical thinking skills and resident development of writing and presentation skills
    ii. Can be found on Microsoft Teams → Pharmacy Residency Program →How to folder
    iii.

C. Preceptor Training
    i. All pharmacists who precept residents are members of RAC.
    ii. Preceptor training
        a. Hospital Pharmacist letter provided by the hospital
        b. At least 2 pharmacy precepting presentations given per year

PGY1 PHARMACY RESIDENCY PROGRAMS

IV. PGY1 Traditional & Non-Traditional Pharmacy Residency Programs

A. Position Description & Purpose:

i. The PGY1 pharmacy residency program builds on Doctor of Pharmacy (Pharm.D.) education and outcomes to contribute to the development of clinical pharmacists responsible for medication-related care of patients with a wide range of conditions, eligible for board certification, and eligible for postgraduate year two (PGY2) pharmacy residency training. The residency will be conducted at Medical Center Health System, which is a 400+ bed system.

B. Program's Administration

i. Erica Wilson, PharmD, BCPS Director of Pharmacy

ii. Ashley Bane, PharmD, BCPS Pharmacy Clinical Coordinator and Pharmacy Practice PGY1 Residency Program Director

C. Residency Educational Outcomes, Goals, & Objectives (2015 ASHP goals and objectives)

i. All PGY1 Pharmacy Residency 2015 competencies, Goals, and Objectives can be found here: PGY1-Harmonized-CAGO-ASHP-BOD-Approved-April-2024

ii. **Introduction**. The four competency areas (Patient Care, Practice Advancement, Leadership, Teaching and Education) and their associated goals and objectives are required and must be included in all programs. Progress toward achievement of a specific objective is assessed using criteria. The use of criteria-based evaluations is required by the Standard for both formative and summative assessments. The example criteria provided for the objectives are intended to help preceptors and residents identify specific areas of successful skill development and areas requiring performance improvement. The criteria provided are examples and are not to be used as a "requirement checklist", nor to be considered a comprehensive or exhaustive topic and/or activity listing. Preceptors may develop their own criteria to assess resident performance, identify areas requiring performance improvement, and meet the intent of the Standard. Resident responsibilities

iii. Become competent in the management of the pharmacy distribution system to work independently in any position within the pharmacy

iv. Participate in hospital committee activities, including but not limited to antimicrobial stewardship committee, drug shortage, medication safety, and pharmacy & therapeutics

v. Participate in the clinical activities provided by the pharmacy

vi. Develop the ability and confidence to independently practice in all clinical settings in the hospital

vii. Enhance communication skills required to become an integral component of the multidisciplinary healthcare team

viii. Provide drug information, in a format applicable to the audience

ix. Participate in the education of other healthcare personnel

x. Complete a project that will provide enhanced patient safety and promote the practice of pharmacy
xi. Work together with the RPD to improve the residency experience for future residents
xii. Complete PharmAcademic evaluations within 7 days of completed learning experience.
xiii. Must complete at the minimum the following learning assignments to receive graduation certificate
    a. Must complete a minimum of 52 weeks and all required core, longitudinal and supplemental elective rotation activities
    b. Must obtain rating of Achieved for Residency for a minimum of 80% of all goals for residency in PharmAcademic
    c. Must complete a manuscript and presentation for the major project
    d. Minimum requirements included on graduation checklist (Appendix A)
    e. Residency Portfolio completed and uploaded

D. Service Commitment/Staffing
    i. PGY1 Traditional Pharmacy Residents will staff at least every 3rd weekend and at least one evening shift every week
        a. The resident does not receive compensation days for weekend coverage, job duties are defined within central pharmacy staff syllabus
    ii. PGY1 Non-traditional Pharmacy Residents: 52 weeks of the two-year period will be staffing, including every 3rd weekend and at least one evening shift every week.

V. **Residency Learning System**

A. Learning Experiences:

Required rotations	Adult Medicine I (4 weeks) Adult Medicine 2 (4 weeks) Critical Care I (4 weeks) Critical Care 2 (4 weeks) Emergency Medicine I (6 weeks) Neonatal Intensive Care Unit/Pediatrics (4 weeks) Transitions of Care (4 weeks) Medication Safety (4 weeks) *Longitudinal Rotations (traditional: during 52 weeks; non-traditional: throughout 2 years of residency rotating during rotations)* Pharmacy Administration (3 months each) • Pharmacy & Therapeutics & Formulary Management • Drug Shortage • Pharmacy Operations & Leadership/Chief Resident • Medication Safety Pharmacy Administration: Pharmacy Operations & Leadership (52 weeks) Pharmacy Conference & Ask a Pharmacist (52 weeks) Antimicrobial Stewardship (52 weeks) Major Project (52 weeks) Central Pharmacy Staffing (52 weeks)
Elective Rotations	Adult Medicine III (4 weeks) Adult Medicine III Cardiology (2-4 weeks) Critical Care III (4 weeks) Emergency Medicine II (4 weeks) Transitions of Care II (2-4 weeks) Nephrology (physician-led, if preceptor available) (2-4 weeks) Infectious Disease (physician-led, if preceptor available) (2-4 weeks) Trauma/Surgery (4 weeks) Pharmacy Practice Management (Clinical Coordinator) (4 weeks) Pharmacy Practice Management (Pharmacy Director) (4 weeks)

B. Learning Experiences

i. Critical Care I cannot be taken until the resident is a licensed pharmacist
ii. NICU cannot be taken until the resident is a licensed pharmacist
iii. Emergency Medicine cannot be taken until the resident has completed Critical Care I
iv. Electives:
    1. Will be taken in the second half of the year unless preceptor availability is limited
    2. Trauma can only be taken after completing either Critical Care II or Internal Medicine II
    3. Emergency Medicine II requires preceptor approval to take

C. Evaluation process
    i. All incoming residents complete the entering interests and goal-based interest evaluations in PharmAcademic in order to convey their goals for the residency. This information is reviewed by the RPD and shared with preceptors at RAC. Additionally, the evaluation is used to generate each resident's initial development plan.
    ii. Preceptors and residents will be provided beginning of rotation and end of rotation checklists and will be encouraged to use these to track resident progress
    iii. Preceptors and residents must submit written feedback documentation for each rotation to address well-performed areas and areas of need-improvement with plan of action
        1. Preceptors and residents will have informal verbal evaluation on a weekly basis
        2. Residents will also have meetings with the RPD to address concerns
        3. For longitudinal rotations or rotations lasting longer than 12 weeks, a summative evaluation will be completed by the residents and preceptors at least quarterly
        4. All PharmAcademic evaluations must be completed within 7 days of due date
            a. Any delays should be discussed with the RPD. The RPD will follow up with late evaluations and determine an immediate plan for correction of missing evaluations.
            b. All evaluations should include examples of specific learning activities and how they support the evaluation of the resident on this outcome/goal/objective. Within the written portion of the assessment, the resident and preceptor should note qualitatively how well the resident performed and any opportunities for improvement. The evaluation should go beyond restating the objectives and should give further insight into performance and areas where improvement is needed. Residents who accurately and effectively self-reflect are able to improve and grow more throughout the residency year.
            c. Goals may be marked as achieved for residency (ACHR) by preceptors and RPD. An objective may be deemed as Achieved for Residency if one or more preceptors give ACH on at least 2 separate occasions (for all objectives under R1.1 and R1.2 the second ACH has to be by IM2 or ICU2). ACHR status can also be obtained during RAC meetings by gathering verbal feedback from preceptors.
            d. To ensure the resident is making adequate program progress towards completion, goals/objectives must be reported and discussed at RAC meetings starting at January of residency year. Proper coaching and counseling should be provided and

assignment of objectives to upcoming rotations if applicable should be done.

D. Guidelines for evaluation of each objective:
    i. ***Needs Improvement (NI):*** objectives marked NI should be discussed at RAC each month and corrective action if indicated.
        1. The resident could not complete tasks or assignments without extensive guidance from start to finish, OR
        2. The resident's written assignments were submitted without adequate time for editing or the initial draft was not the resident's best effort OR
        3. The resident could not complete tasks or assignments within the specified timeline, OR
        4. The resident could not gather information to completely answer patient care questions or develop comprehensive pharmacotherapy plans, OR
        5. The resident did not completely document patient care activities, OR
        6. The resident failed to directly communicate with a preceptor or staff concerning patient care or rotation responsibilities, OR
        7. The resident failed to self-identify gaps in knowledge and proactively look up information regarding these without being asked/identified by preceptor, OR
        8. The resident is not meeting patient based and/or process-based rotation outcomes as defined by rotation description, OR
        9. The resident committed other unprofessional actions and requires remediation, OR
        10. Resident is not prepared for rotation assigned task/duty
    ii. ***Satisfactory Progress (SP):*** this applies to an objective whose mastery requires skill development conducted over multiple learning experiences. In the current experience the resident has progressed at expected performance to attain full mastery by the end of the rotation.
        1. At the end of a rotation, perform most activities without significant input from the preceptor but seeks guidance when appropriate.
        2. There is evidence of significant improvement during the rotation, even if it is not complete mastery of the task. It is expected the resident will be able to attain complete mastery based on future rotations.
        3. The resident is at the expected state for the time of residency year.
        4. There is a possibility the resident can receive NI on future rotations in the same goal in which SP was received if the resident does not perform at least at the same level as previously noted. It is expected that preceptors will provide verbal and written objective feedback in areas where residents have met satisfactory progress
    iii. ***Achieved (ACH):*** The resident has fully mastered the goal for the level of residency training to date. No further instruction or evaluation is required in subsequent learning experiences. This means that the resident has consistently performed the task or expectation without guidance. It is expected that

preceptors will provide verbal and written objective feedback in areas where residents have achieved.

1. Resident is able to practice independently with limited preceptor supervision/preceptor mainly functions in “facilitation” preceptor role.
2. Reside is able to perform skill and self-monitor quality.
3. Resident has mastered the objective and consistently performed the task/expectation with limited to no guidance.

iv. ***Achieved for Residency (ACHR):*** The resident’s preceptors and Program Director will collaborate throughout the residency year to determine if the resident has demonstrated consistency between rotation evaluations of goals and objectives. This means that the resident can consistently perform the task or has fully mastered the objective and performed this task consistently in various rotation experiences. At such time, the RPD has the ability to mark the resident as “achieved for the residency”. This means that the resident will no longer be evaluated on this goal, but that any preceptor has the opportunity to provide additional feedback as necessary. If additional feedback provided by a preceptor places the resident at a Needs Improvement the Residency Director can remove the Achieved for Residency status on that objective.

1. A resident should achieve a score of “achieved” on two rotations. For all objectives under R1.1 and 1.2 one of the “achieved” has to be ICU2 or IM2, for the same objective before marking ACHR.
2. This can be discussed and overridden by RAC or the RPD as needed (i.e., end of residency year).
3. Objectives evaluated in a singular learning experience may be marked ACHR after a one-time evaluation of “achieved”.

E. Rotation Transition:

i. Residents are responsible for sending progress toward residency completion checklist to preceptor for the next rotation as well as link or location of electronic portfolio. The preceptors use this information to tailor the rotation to help the resident achieve residency requirements and objectives.

ii. Current preceptor collects feedback from other providers in the team and incorporates this information into the final evaluation.

iii. At RAC resident performance will be discussed with preceptors. Items for discussion include well-performed areas, areas in need of improvement, items completed during the rotation and other healthcare providers’ feedback.

VI. Codes/Rapid Response expectations

A. Residents will attend ACLS training and a refresher code/rapid response course

B. Prior to ACLS training

i. Resident expected to read the ACLS book

ii. Be prepared for class

C. Residents will respond to rapids/codes for all patients they are responsible for on rotations

i. Residents should be prepared to draw up meds and answer questions

ii. Preceptors will model first then coach residents through following rapids/codes

D. After January 1
    i. If staffing an internal medicine shift residents will attend rapids by themselves

VII. PGY1 Program Appendices

A. Appendix A. PGY1 Pharmacy Residency Completion Checklist

APPENDIX A

PGY1 Residency Completion and Certification Checklist

PGY1 resident: Residency Year: **2025-2026**

Purpose: To receive a certificate of completion from the Medical Center Health System residency program, residents must complete the listed requirements below. This will be reviewed throughout the year by mentor, RC, RPD and RAC to track residents' progress and at the end of residency to determine if the resident will graduate the program. Due date is just by end of the year unless otherwise specified.

Residency requirements	**Name of Assignment**	**Date completed**	**Sign off by Preceptor**	**Sign off by RPD**
An achievement of at least 80% of all goals marked as achieved for residency				
Community or Pharmacy Dpt Involvement (at least 1 approved events)				
Ask A Pharmacist (Due by Dec 31) (DI, DCR, Drug Monograph, MUE)				
Ask A Pharmacist (DI, DCR, Drug Monograph, MUE)				
Didactic lecture 1				
Didactic lecture 2				
Drug Class Review				
Drug Monograph				
In-service 1				
In-service 2				
n-service 3				
n-service 4				
Journal Club 1 (Due by Dec 31)				
Journal Club 2				
Journal Club 3				
MUE 1				

Last Updated 6-18-2025

PGY1 Residency Completion and Certification Checklist

PGY1 resident: Residency Year: **2025-2026**

MUE 2				
Patient Case 1				
Patient Case 2				
Major Project presentation				
Major Project proposals for next year				
Major Project final manuscript				
Residency portfolio Completed				
Rotation Completion of all required core, longitudinal, and elective rotations				

PGY1 Pharmacy Resident: _____ Date: _____

Residency Program Director _____ Date: _____

PGY2 EMERGENCY MEDICINE PHARMACY RESIDENCY PROGRAM

I. PGY 2 Emergency Medicine Pharmacy Program

A. Position Description

i. The pharmacy residency is an emergency medicine postgraduate year two (PGY2) residency program. The program intends to build upon the PGY1 general year residency with the intent of training the resident to be able to handle a wide variety of situations that occur in emergency medicine. The residency will be conducted at Medical Center Health System, which is a 400+ bed system. The hospital's emergency department has 14 high acuity rooms and 25 lower acuity rooms. The ED sees 60,000 patients a year on average.

B. Purpose:

i. PGY2 pharmacy residency programs build on Doctor of Pharmacy (Pharm.D.) education and PGY1 pharmacy residency programs to contribute to the development of clinical pharmacists in specialized areas of practice. PGY2 residencies provide residents with opportunities to function independently as practitioners by conceptualizing and integrating accumulated experience and knowledge and incorporating both into the provision of patient care or other advanced practice settings. Residents who successfully complete an accredited PGY2 pharmacy residency are prepared for advanced patient care, academic, or other specialized positions, along with board certification, if available.

C. Program Administration

i. Erica Wilson, PharmD, BCPS, Director of Pharmacy

ii. Laura Branum, PharmD, BCEMP, Emergency Medicine Pharmacy PGY2 Residency Program Director

D. Residency Educational Outcomes, Goals, & Objectives

i. All PGY2 Emergency Medicine competencies, Goals, and Objectives can be found here: https://www.ashp.org/-/media/assets/professional-development/residencies/docs/pgy2-emergency-medicine-cago-2018.ashx?la=en&hash=86CD661BA30149E308822BB4A11B731A3BA37B81

ii. Introduction - The competency areas, goals, and objectives are to be used in conjunction with the ASHP Accreditation Standard for Postgraduate Year Two (PGY2) Pharmacy Residency Programs. The first six competency areas described herein are required, and the others are elective. The required competency areas and all of the goals and objectives they encompass must be included in all programs. Programs may add one or more required additional competency areas from the elective competency area choices to meet program-specific needs. Programs selecting an additional competency area are not required to include all of the goals and objectives in that competency area. In addition to the potential additional competency areas described in this document, programs are free to create their own unique competency areas with associated goals and objectives based on the specific needs of their program. Each of the objectives associated with the goals encompassed by the program's selected

program competency areas (required and additional) must be taught and evaluated at least once during the residency year. Elective competency area(s) may also be selected for specific residents when creating their residency development plan.

1. Each of the objectives listed in this document has been classified according to educational taxonomy (cognitive, affective, or psychomotor) and level of learning. An explanation of the taxonomies is available elsewhere.
2. Competency areas for PGY1 residencies are available on the ASHP website. PGY2 competency areas, goals, and objectives in emergency medicine pharmacy are differentiated from those from PGY1 by specialization and the expectation of PGY2 residents for greater work competence and proficiency.

E. Requirements
   i. Applicants must have completed an ASHP-accredited PGY1 pharmacy residency or one in the ASHP accreditation process (i.e., one with candidate or preliminary accreditation status).

F. Resident responsibilities
   i. Become competent in the management of the pharmacy distribution system to work independently in any position within the pharmacy
   ii. Participate in hospital committee activities, including but not limited to: infection control committee, code blue committee, emergency preparedness committee, pharmacy education committee, and quality and patient safety council
   iii. Participate in the clinical services provided by the pharmacy
   iv. Enhance communication skills required to become an integral component of the multidisciplinary healthcare team
   v. Provide drug information, in a format applicable to the audience
   vi. Participate in the education of pharmacy students or residents
   vii. Complete a project that will provide enhanced patient safety and promote the practice of pharmacy
   viii. Work together with the RPD and RC to improve the residency experience for future residents
   ix. Graduation criteria:
      1. The resident must obtain rating of achieved for residency for a minimum of 80% of all goals for residency in PharmAcademic with no Need Improvement (NI) of all objectives set forth in the program by the end of the residency year
      2. Resident portfolio must include at the minimum 10 pharmacy newsletters for the emergency room and 2 didactic lectures
      3. The resident must complete a manuscript for the major project, podium presentation, and submit it for publication
   x. Staffing

1. In order for the resident to gain adequate exposure to emergency medicine pharmacy services they will have a staffing obligation which includes:
    a. Staffing in the emergency department every 3rd Friday, Saturday, and Sunday
        i. Staffing responsibilities are in addition to the resident's normal schedule, and the resident will not be compensated with days off during the week
        ii. Staffing weekends are not eligible for PPL, but the resident may switch with another pharmacist if it is necessary for them to have one of these weekends off. A resident must inform the RPD, RC and the DOP about any arrangements to trade a staffing responsibility with another pharmacist
    b. Staffing on their current rotation when their preceptor is absent if there is not another pharmacist scheduled to cover for the preceptor
    c. PRN coverage of staffing positions (for compensation) is allowed after October of residency year if supervisor and/or director of pharmacy approves
    d. PRN coverage of clinical pharmacist positions (for compensation) will be allowed as a last effort to cover needed shifts despite not meeting above criteria (xi(c)) if the following are true
        i. Preceptor in area needing coverage that has had resident states resident can cover majority of service independently (consults, order verification, profile review, rounding, physician and nursing communication.)
    e. Resident may be pulled for coverage of shifts while on another rotation if approved by current preceptor and preceptor of the area in need of coverage. See above for criteria for resident to cover independently (II(A(xi(c), if resident cannot cover independently the criteria listed in (II(A(xi(d)) must be met. This may only occur twice per rotation at maximum.
    f. Resident is required to staff one major and minor hospital holiday. Resident will be able to choose which major and minor holiday at the start of the residency program. One major holiday consists of a paired grouping as follows: Christmas Eve/Christmas Day, Thanksgiving/Black Friday, New Years Eve/New Years Day. Minor includes one of the following: July 4th, Easter, Labor Day, Memorial Day

G. Learning Experiences
    i. Required rotations

1. Emergency Medicine I (6 weeks)
2. Emergency Medicine II (nights) (6 weeks)
3. Emergency Medicine III (6 weeks)
4. Emergency Medicine IV (6 weeks)
5. Emergency Medicine V (midshift) (6 weeks)
6. Critical Care I (6 weeks)
7. Trauma/Surgery I (4-6 weeks)
8. NICU (Unless have previously completed NICU rotation) (4 weeks)

ii. Elective rotations (4 to 6 weeks)
1. Administration
2. Elective rotations based on availability and resident interest

iii. Longitudinal Rotations
1. EMS ride along
2. Emergency Committees (rapid response, code blue, emergency preparedness)
3. Newsletter articles for distribution within the ER
4. Rapid response training for PGY1 residents
5. CME Presentation for Texas Tech Physicians

iv. Concentrated Experiences
1. Certifications
   a. BLS (required)
   b. ACLS (required)
   c. PALS (required)
   d. ATLS audit (required)
2. ACEP conference or comparable conference
3. ASHP Midyear Poster Presentation (optional)
4. Texas Tech Research Days Poster Presentation/Podium Presentation

H. Evaluation process

i. All incoming residents complete the entering interests and goal-based interest evaluations in PharmAcademic in order to convey their goals for the residency. This information is reviewed by the RPD and shared with preceptors at RAC. Additionally, the evaluation is used to generate each resident's initial development plan.

ii. Preceptors and residents will have informal verbal evaluation on weekly basis
1. For longitudinal rotations or rotations lasting longer than 12 weeks, a summative evaluation will be completed by the residents and preceptors at least quarterly
2. All PharmAcademic evaluations must be completed during the last week of rotation.
   a. Any delays should be discussed with the RPD. The RPD will follow up with late evaluations and determine an immediate plan for correction of missing evaluations.
   b. All evaluations should include examples of specific learning activities and how they support the evaluation of the resident

on this outcome/goal/objective. Within the written portion of the assessment, the resident and preceptor should note qualitatively how well the resident performed and any opportunities for improvement. The evaluation should go beyond restating the objectives and should give further insight into performance and areas where improvement is needed. Residents who accurately and effectively self-reflect are able to improve and grow more throughout the residency year.

c. Goals may be marked as achieved for residency (ACHR) by preceptors and RPD. An objective may be deemed as ACHR if one or more preceptors give ACH on at least 2 separate occasions. ACHR status can also be obtained during RAC meeting by gathering verbal feedback from preceptors.
d. To ensure the resident is making adequate program, a minimum of one-third of goals/objectives must be ACHR by January of residency year. If this is not met, coaching and counseling will be provided in January as well as a new deadline to meet a certain amount of objectives as SP/ACH with no NI by a date determined by the RAC. Goals are discussed at RAC meetings using the resident specific reports from PharmAcademic.

I. Guidelines for evaluation of each objective:
    i. ***Needs Improvement (NI):*** objectives marked NI should be discussed at RAC each month and corrective action if indicated.
        1. The resident could not complete tasks or assignments without extensive guidance from start to finish, OR
        2. The resident's written assignments were submitted without adequate time for editing or the initial draft was not the resident's best effort OR
        3. The resident could not complete tasks or assignments within the specified timeline, OR
        4. The resident could not gather information to completely answer patient care questions or develop comprehensive pharmacotherapy plans, OR
        5. The resident did not completely document patient care activities, OR
        6. The resident failed to directly communicate with a preceptor or staff concerning patient care or rotation responsibilities, OR
        7. The resident failed to self-identify gaps in knowledge and proactively look up information regarding these without being asked/identified by preceptor, OR
        8. The resident is not meeting patient based and/or process-based rotation outcomes as defined by rotation description, OR
        9. The resident committed other unprofessional actions and requires remediation, OR
        10. Resident is not prepared for rotation assigned task/duty
    ii. ***Satisfactory Progress (SP):*** this applies to an objective whose mastery requires skill development conducted over multiple learning experiences. In the current

experience the resident has progressed at expected performance to attain full mastery by the end of the rotation (for example: objective 1.1.3 to 1.1.6).

1. At the end of a rotation perform most activities without significant input from the preceptor but seeks guidance when appropriate.
2. There is evidence of significant improvement during the rotation, even if it is not complete mastery of the task. It is expected the resident will be able to attain complete mastery based on future rotations.
3. There is a possibility the resident can receive NI on future rotations in the same goal in which SP was received if the resident does not perform at least at the same level as previously noted. It is expected that preceptors will provide verbal and written objective feedback in areas where residents have met satisfactory progress

iii. ***Achieved (ACH):*** The resident has fully mastered the goal for the level of residency training to date. No further instruction or evaluation is required in subsequent learning experiences. This means that the resident has consistently performed the task or expectation without guidance. It is expected that preceptors will provide verbal and written objective feedback in areas where residents have achieved. A resident should receive a score of ACH on two consecutive rotations for the same objective before marking ACHR; this can be discussed and overridden by RAC or the RPD as needed (i.e., end of residency year)

iv. ***Achieved for Residency (ACHR):*** The resident's preceptors and Program Director will collaborate throughout the residency year to determine if the resident has demonstrated consistency between rotation evaluations of goals and objectives. This means that the resident can consistently perform the task or has fully mastered the objective and performed this task consistently in various rotation experiences. At such time, the preceptors or RPD have the ability to mark the resident as "achieved for the residency". This means that the resident will no longer be evaluated on this goal, but that any preceptor has the opportunity to provide additional feedback as necessary.

J. Rotation Transition:
   i. Current preceptor collects feedback from other providers in the team and incorporates this information into the final evaluation.
   ii. At each RAC meeting, preceptors will discuss past resident performance on rotations. Items for discussion include well-performed areas, areas of need improvement, items completed during the rotation and other healthcare providers' feedback.

K. PGY2 early commitment policy/procedure (program administration will decide if early commitment process will be pursued each year and will alert all PGY1s):
   i. PGY1 residents at Medical Center Hospital can be considered for early commitment and match to a PGY2 program. Selection of residents for the early commitment process will be selected according to the following procedures.

1. PGY1 residents with an interest in committing to a PGY2 program through the early commitment process prior to the match will need to notify the PGY2 program director by November 1st of each year.
2. The PGY2 program director will discuss with the residency selection committee and will determine if they wish to proceed with the early commitment process or wait for the match process.
3. If more than one PGY1 resident expresses interest in a PGY2 program than there are positions available, then a full interview process will be utilized to select a PGY2 resident. (This process is used during the normal match process.) The program director may also decide to revert to the match process for selection of PGY2 residents.
4. If the PGY2 program director decides to pursue the early commitment process, the PGY2 program director will request the following:
    a. A letter of recommendation from the PGY1 program director indicating that the PGY1 resident is progressing as planned within the PGY1 program, the PGY1 resident has no significant deficiencies, and the PGY1 resident demonstrates qualities consistent with continued employment at Medical Center Hospital. All application materials from the PGY1 program will be reviewed by the PGY2 director.
    b. An interview with the PGY1 resident will be scheduled. This can be an abbreviated interview process with the PGY2 program director and the selection committee. The interview will be attempted to be scheduled approximately 2 weeks after November 1st of the year. Decisions on candidate will be made prior to ASHP Midyear meeting. PGY2 director may choose to proceed to the general match in March despite having candidates interview for the position.
5. Once a PGY2 resident is selected, all applicable early commitment form(s) will be completed and filed with the National Matching Service

II. PGY2 Emergency Medicine Program Appendices

A. **Appendix** PGY2 Emergency Medicine Residency Completion Checklist

Purpose: To receive a certificate of completion from the Medical Center Health System residency program, residents must complete the listed requirements below. This will be reviewed throughout the year by RC, RPD and RAC to track residents' progress and at the end of residency to determine if the resident will graduate the program. All topics must either have direct patient experience or indirect experience (topic discussion) unless such topic is marked as elective.

Topic	Direct Experience	Indirect Experience
CARDIOLOGY		
Acute Coronary Syndrome		

Acute Decompensated Heart Failure		
Hypertensive Urgency/Emergency		
Acute Aortic Dissection	**(not required)**	
Arrhythmias	**(not required)**	
Pericardial tamponade (elective)	**(not required)**	
Pericarditis (elective)	**(not required)**	
Pulmonary Hypertension (elective)	**(not required)**	
DERMATOLOGY		
Burns	**(not required)**	
Drug Reactions	**(not required)**	
Stevens Johnson Syndrome/TEN	**(not required)**	
Topical and Local Anesthesia	**(not required)**	
Erythema multiforme (elective)	**(not required)**	
Gout exacerbation (elective)	**(not required)**	
Rash (elective)	**(not required)**	
ENDOCRINE		
Glycemic Control		
Hyperglycemic Crisis		
Adrenal crisis/insufficiency	**(not required)**	
Myxedema Coma	**(not required)**	
Thyroid Storm	**(not required)**	
SIADH (elective)	**(not required)**	
EMERGENCY PREPAREDNESS		
Decontamination	**(not required)**	
Disaster Preparedness/National Incident Management System	**(not required)**	
Medical Surge Capacity and Capability	**(not required)**	
Advanced HAZMAT life support (elective)	**(not required)**	
Bioterrorism (elective)	**(not required)**	
Nerve agents (elective)	**(not required)**	
Radiation Exposure (elective)	**(not required)**	
ENVIRONMENTAL		
Hyperthermia		
Hypothermia		
Altitude Illness (elective)	**(not required)**	
Carbon Monoxide (elective)	**(not required)**	
Drowning/Near Drowning (elective)	**(not required)**	
GI AND HEPATIC		

Acute Upper and Lower GI Bleed		
Nausea/Vomiting		
Acute Liver Failure/Cirrhosis	**(not required)**	
Constipation/Diarrhea	**(not required)**	
Peptic Ulcer Disease	**(not required)**	
Esophageal Foreign Body (elective)	**(not required)**	
Pancreatitis (elective)	**(not required)**	
HEMATOLOGY		
Anticoagulation Reversal		
Thromboembolic Disease		
Benign Heme Disorders (anemia, hemophilia, sickle cell disease)	**(not required)**	
Coagulopathies	**(not required)**	
Hypercalcemia of Malignancy (elective)	**(not required)**	
Tumor Lysis Syndrome (elective)	**(not required)**	
INFECTIOUS DISEASE		
Bites		
Influenza		
Pneumonia		
Sepsis		
STIs		
SSTIs		
UTIs		
Vaccinations		
Conjuctivitis	**(not required)**	
Dental Infections	**(not required)**	
Epiglottitis	**(not required)**	
Endocarditis	**(not required)**	
Intra-abdominal Infections	**(not required)**	
Meningitis	**(not required)**	
Occupational/non-occupational antiretroviral post exposure prophylaxis	**(not required)**	
Sinusitis/otitis media	**(not required)**	
Streptococcal pharyngitis	**(not required)**	
Bone/Joint Infections (elective)	**(not required)**	
Febrile Neutropenia (elective)	**(not required)**	
Food and Waterborne Illnesses (elective)	**(not required)**	
Hepatitis (elective)	**(not required)**	

Parasites/worms (elective)	**(not required)**	
Toxic Shock Syndrome (elective)	**(not required)**	
Tuberculosis (elective)	**(not required)**	
Wilderness Medicine (elective)	**(not required)**	
NEUROLOGY		
Acute Hemorrhagic Stroke		
Acute Ischemic Stroke		
Status Epilepticus/Seizures		
Increased ICP Management	**(not required)**	
Migraine and Headaches	**(not required)**	
Myasthenia Gravis (elective)	**(not required)**	
Ventriculostomy (elective)	**(not required)**	
OBSTETRICS		
Ectopic pregnancy	**(not required)**	
Preeclamsia and Eclampsia	**(not required)**	
Resuscitation in Pregnancy	**(not required)**	
PAIN AND SEDATION		
Acute Agitation		
Acute Pain Management		
Post-Intubation Sedation/Analgesia		
Procedural Sedation		
Psychosis and Delirium	**(not required)**	
PULMONARY		
Asthma Exacerbation		
COPD Exacerbation		
RSI		
Mechanical Ventilation	**(not required)**	
Noninvasive Airway Management	**(not required)**	
ARDS (elective)	**(not required)**	
Pneumothorax (elective)	**(not required)**	
RENAL AND GENITOURINARY		
Acid Base Disorders		
AKI/ESRD		
Fluids and Electrolytes		
Priapism	**(not required)**	
Renal colic/urolithiasis	**(not required)**	
Renal Replacement Therapy	**(not required)**	
Rhabdomyolysis	**(not required)**	
RESUSCITATION		
ACLS		
Anaphylaxis		

Hemodynamic Monitoring/Management		
Routes of Medication Administration		
Shock States		
Pediatric Advanced Life Support	**(not required)**	
SPECIAL POPULATIONS		
Age-specific dosing considerations	**(not required)**	
Angioedema	**(not required)**	
Pediatric/neonatal Febrile Seizures	**(not required)**	
Common Infections in Children (elective)	**(not required)**	
TOXICOLOGY		
Acetaminophen		
Approach to the Toxic Patient		
Gastric Decontamination/Elimination		
Opioids		
Salicylates		
Withdrawal Syndromes		
Antidepressants/Antipsychotics	**(not required)**	
Beta Blockers and Calcium Channel Blockers	**(not required)**	
Occupational Exposures	**(not required)**	
Sedatives	**(not required)**	
Antiepileptics (elective)	**(not required)**	
Antihypertensives (elective)	**(not required)**	
Caustic Ingestions (elective)	**(not required)**	
Cyanide (elective)	**(not required)**	
Digitalis (elective)	**(not required)**	
Heavy Metals (elective)	**(not required)**	
Iron (elective)	**(not required)**	
Neuroleptic Malignant Syndrome (elective)	**(not required)**	
Poisonous Plants (elective)	**(not required)**	
Toxic Alcohols (elective)	**(not required)**	
TRAUMA		
Antibiotic Prophylaxis		
Coagulopathy of Trauma	**(not required)**	
Open Fractures	**(not required)**	
Spinal Cord Injury	**(not required)**	

Traumatic Brain Injury	**(not required)**	
Trauma Resuscitation	**(not required)**	
Massive Transfusion (elective)	**(not required)**	
Thorocostomy/thoracotomy (elective)	**(not required)**	

Residency Requirements	**Name of assignment**	**Date completed**	**Sign off by RC or RPD**
September Newsletter			
October Newsletter			
November Newsletter			
December Newsletter			
January Newsletter			
February Newsletter			
March Newsletter			
April Newsletter			
May Newsletter			
June Newsletter			
Didactic lecture 1			
Didactic lecture 2			
Grand Rounds/CME Presentation			
Major project IRB protocol			
Major Project podium presentation			
Major project final manuscript			
Completion of all required core and longitudinal rotations			
An achievement of at least 80% of all goals marked as achieved for residency in PharmAcademic			

PGY2 Pharmacy Resident _____

Residency Program Director _____