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Message from the Program Director . . .

We are pleased that you have entrusted our faculty and staff with the opportunity to assist you with your orthopaedic surgery education: it is a privilege we gladly accept. We are looking forward to working with you as you grow into your new life as an orthopaedic surgeon in the 21st Century.

The information and material contained in this Handbook has been prepared expressly for use by the orthopaedic surgery resident within the USA Department of Orthopaedic Surgery. It is designed to orient you to the goals and objectives of the Department of Orthopaedic Surgery and to aid in defining your roles and responsibilities as an orthopaedic surgery resident.

Our faculty and staff are genuinely committed to providing you with the finest education possible. We are dedicated to the educational objectives of the Accreditation Council of Graduate Medical Education (ACGME) and the objectives set forth in this Handbook. Each faculty member has chosen to teach and practice academic medicine as a way to contribute to the medical community of today . . . and tomorrow.

Our goals are the same as yours: for you to become a well-educated, competent, compassionate, and skilled orthopaedic surgeon. As physicians and orthopaedic surgeons we face many challenges today. It is our hope that during the next five years you will develop the knowledge and the tools you need to face and overcome these challenges. The faculty and staff of the Department of Orthopaedic Surgery are here for you. Our hope is that we can grow together. Welcome!

Frederick N. Meyer, MD
Professor and Chairman
Program Director

University of South Alabama Medical Center
Mission Statement

To provide a system of hospital services and resources that enhances the health status of the community and supports health care, education and research.

Vision

We strive to be the hospital of choice throughout the region for health care and employment by providing excellence in patient care, education, and research, with an emphasis on highly specialized care.

Values

Patient First – Our patients deserve our best effort. They are the primary focus of activities in our organization. We are committed to fulfilling their needs and surpassing their expectations.

Integrity and Ethics – We adhere to and advocate the highest principles of conduct in all actions and decisions.

Quality of Care – We are committed to a standard of quality that results in excellence. We strive to provide professional and compassionate service to our patients and our region, using state-of-the-art technology in a safe, friendly, attractive, and comfortable environment.

Teamwork – We work hard to understand and value each other’s role so that we can more effectively work together in an effort to achieve our vision.

Change and Creativity – We are committed to pursuing innovative ways to meet patient needs and assure patient safety.

Cost Effectiveness – We have a responsibility to our patients to act prudently when dealing with their resources.

Tips of the trade . . .

- Work ethic, demeanor, and personal appearance reflect quality, professionalism, and pride in your role as an orthopaedic surgery resident.
Collaboration and cooperation with associates at every level increases your opportunity to provide the best patient care. Your appropriate interaction with attending physicians, nursing staff, ancillary personnel, and colleagues positively enhances your role as an orthopaedic surgery House Staff physician.

Orthopaedic surgery residents are employees of the University of South Alabama Medical Center. The *House Staff Policy and Procedures Manual* and the *USAMC Staff Employee Handbook* details hospital rules, grievance and discipline procedures, benefits and services. These publications are distributed at your orientation and are available from the House Staff office, Chairman’s office, and your residency coordinator.

Please report and promptly document all conflicts/incidents to the Chairman’s office.

**Statement of Resident’s General Responsibilities**

In accordance with our goals, this training program provides residents with an extensive experience in the art and science of orthopaedic surgery in order to achieve excellence in the diagnosis, care, and treatment of patients. Residents are expected to:

- Assume responsibilities for the safe, effective, and compassionate care of patients consistent with the resident’s level of education and experience. When patient care is involved, the resident at all times will function under the supervision of the attending orthopaedic surgeon in charge of the care of the patient.
- Participate fully in the educational and scholarly activities of the Department of Orthopaedic Surgery. This includes responsibility to participate in the education and training of other residents, medical students, and allied health students.
- Develop a personal program of self-study and professional growth under the guidance of the faculty of the Department of Orthopaedic Surgery.
- Participate in departmental and institutional programs, committees, and activities involving the medical staff as assigned by the program director. The resident is expected to adhere at all times to established policies, procedures, and practices of the institution.
- Participate in the evaluation of the program and its faculty.
- Develop an understanding of ethical, socio-economic, and medical legal issues that affect the practice of orthopaedic surgery.
- Maintain up-to-date charts, records, and reports.
- Adhere to ACGME, institutional, and program requirements.

**Administrative Information**

**Departmental Support Staff**

| Practice Director | Drew Krogsgard | (251) 665-8280 |
Coordination of secretarial support for resident activities is generally provided through the Residency Program Coordinator’s office. Requests for assistance should be made with as much advance notice as possible.

**Employment Contract**

Yearly contracts become available for the resident’s review and signature during the month of June. Original contracts are retained in the House Staff office: copies are filed in the resident’s departmental files.

**Insurance Benefits**

- **Health Insurance:** Provided at same co-pay as other employees.
- **Life Insurance:** Provided free by the hospital.
- **Disability Insurance:** Provided free by hospital.
- **Professional Liability Insurance:** Provided free by hospital for all residency-related work.

**Medical Malpractice Insurance**

The USA Office of Risk Management and Insurance administers the USA Professional Liability Trust Fund which provides and oversees USA’s medical malpractice insurance coverage. The Risk Management Office also provides information and/or consultation services for many legal issues. The USA Risk Management Office is located on campus (CSAB 214): telephone (251) 460-6232. The following guidelines apply regarding medical risk management procedures:

- Notify attending staff immediately of any potential problems.
- Requests for depositions, professional opinions, etc., should be referred to the residency coordinator.
- Never alter a medical record.
- Never speak to parties informally.

**Educational Goals**

**American Board of Orthopaedic Surgery**

*General Statement of Educational Goals for Orthopaedic Surgery*
The goal of orthopaedic education is to prepare orthopaedic residents to be competent and ethical practitioners of orthopaedic surgery. To fulfill this goal, applicants for certification must have received through orthopaedic residency:

A. Education in the entire field of orthopaedic surgery, including in-patient and outpatient diagnosis and care as well as operative and non-operative management and rehabilitation.
B. The opportunities to develop, through experience, the necessary cognitive, technical, interpersonal, teaching, and research skills.
C. The opportunity to create new knowledge and to become skilled in the critical evaluation of information.
D. Education in the recognition and management of basic medical and surgical problems.
E. An evaluation of ethical performance.

USA Department of Orthopaedic Surgery
General Goals and Objectives for USA Orthopaedic Surgery Residents

1. During your five years of residency training at the University of South Alabama, you will study the prevention of musculoskeletal diseases, disorders, and injuries and their treatment by medical, surgical, and physical methods. Through participation in clinical and didactic activities you will develop the knowledge, attitudes, and skills needed to formulate principles and assess, plan, and initiate treatment of adult orthopaedic problems, including joint reconstruction; pediatric orthopaedic problems, including pediatric trauma; trauma, including multi-system trauma; surgery of the spine, including disk surgery, spinal trauma, and spinal deformities; hand surgery; foot surgery in adults and children; athletic injuries, including arthroscopy, metastatic disease; and orthopaedic rehabilitation, including amputations and post-amputation care. You will participate in the pre-operative, intra-operative and post-operative care of patients with these orthopaedic conditions. In addition, you will learn orthopaedic oncology, rehabilitation of neurological injury and disease, spinal cord injury rehabilitation, orthotics and prosthetics, and the ethics of medical practice.

2. You will gain and demonstrate knowledge about established and evolving biomedical, clinical, and cognitive (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. You will be able to demonstrate an investigatory and analytic thinking approach to clinical situations and know and apply the basic and clinically supportive sciences that are appropriate to orthopaedic surgery.

3. You will learn to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. As part of this you will learn to:

- Communicate effectively and demonstrate caring and respectful behavior when interacting with patients and their families.
- Gather essential and accurate information about your patients.
- Make informed decisions about diagnostics and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.

- Develop and carry out patient management plans.

- Demonstrate the ability to practice culturally competent medicine.

- Use information technology to support patient care decisions and patient education.

- Perform competently all medical and invasive procedures considered essential for the practice of orthopaedic surgery.

- Provide health care services aimed at preventing health problems or maintaining health.

- Work with health care professionals, including those from other disciplines, to provide patient-focused care.

4. You will learn to investigate and evaluate your own patient care practices, appraise and assimilate scientific evidence and improve your patient care practices. You will learn how to:

   - Analyze practice experience and perform practice-based improvement activities using a systematic methodology.

   - Locate, appraise, and assimilate evidence from scientific studies related to your patients’ health problems.

   - Obtain and use information about your own population of patients and the larger population from which your patients are drawn.

   - Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.

- Use information technology to manage information, access on-line medical information, and support your own education.

- Facilitate the learning of students and other health care professionals.

5. You will be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, your patients’ families, and professional associates. You will learn to:

   - Create and sustain a therapeutic and ethically sound relationship with patients.
• Work effectively with others as a member or leader of a health care team or other professional group.

6. You will gain a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. You will learn to:

• Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society and the profession; and a commitment to excellence and on-going professional development.

• Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.

• Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities.

• Demonstrate sensitivity and responsiveness to fellow health care professionals’ culture, age, gender, and disabilities.

7. You will learn to become aware of and responsive to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. You will learn to:

• Understand how your patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect your own practice.

• Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

• Practice cost-effective health care and resource allocation that does not compromise quality of care.

• Advocate for quality patient care and assist patients in dealing with system complexities.

• Know how to collaborate with health care managers and health care procedures to assess, coordinate, and improve health care and know how these activities can affect system performance.

8. You will gain progressive experience with these skills as you advance through your education in the USA Department of Orthopaedic Surgery.
NOTES:

Educational Conferences

Monday Conference Session
Orthopaedic Surgery residents and faculty members attend educational conferences held every Monday beginning at 5:30 pm. The attending physicians organize and rotate topics to provide opportunities for review as well as to explore changes and advancements in orthopaedic surgery. Monday conferences include structured basic and clinical science teaching sessions conducted on the first, second, and third Monday. Mortality and Morbidity conferences are held on the fourth Monday of each month. Residents are prepared for conferences by advance notice of textbook review and reading assignments. Monday conferences also include pathology and anatomy lectures. Pathology lectures feature interesting discussions led by chief residents. Anatomy lectures discuss pertinent anatomy and technical surgical approaches, in addition to relevant presentations and anatomical dissection review. Orthopaedic In-Training Examination preparation is supported by a study/review on Tuesday evenings usually beginning in July and continuing through October.
**Grand Rounds**

Grand Rounds is scheduled in the Knollwood Hospital Long Term Care Auditorium every Friday at 7:30 am (not 7:35 or 7:40!) unless otherwise notified. Please plan ahead: late arrivals are discourteous and distracting to both the presenter and to the audience.

“Interesting Case Presentations” are included in the Grand Rounds schedule once each month. The services of Hand, Sports Medicine, Pediatrics, and Trauma are required to keep a log of at least three (preferably four) interesting cases. A service will be assigned each month to present at the “Interesting Case” Grand Rounds meeting.

A sign-in sheet is provided and represents the attendance report filed with the Continuing Medical Education office; it is the official documentation of your Grand Rounds attendance. Please do not forget to “sign-in.” One CME unit is granted for attendance to each Grand Rounds conference unless otherwise noted.

For the Grand Rounds schedule, each PGY 3, 4, 5 orthopaedic surgery resident will be responsible for two Grand Rounds presentations. The opportunity to evaluate Grand Rounds presentations is offered at least quarterly.

**Journal Club**

Journal Club meets the 2nd Wednesday of each month at 6:30 pm (usually at a local restaurant). Notices citing the date, meeting location, and reading assignments are distributed in advance to the residents’ mailboxes located on the 2nd floor at 2 Medical Park. The administrative chief resident, with the review and approval of departmental attending physicians, makes assignments from the JBJS issue of the previous month. In addition, attending physicians assign other pertinent articles for review and discussion.

**General Competencies**

A comprehensive approach is used to incorporate the core competencies into the USA Orthopaedic Surgery Residency Training Program. The integration of consistent, practical, and multi-faceted methodology ensures that teaching of the core competencies occurs throughout the curriculum and at all levels of training. Toward this end, our Program defines the specific knowledge, skills, and attitudes required and also provides the broad educational experiences needed for our residents to demonstrate:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.

5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

6. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

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**Resident Duty Hours**

**Duty Hours**
Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (inpatient and outpatient) administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Duty hours are limited to 80 hours per week averaged over a four week period, inclusive of all in-house call activities but exclusive of telephone call from home.

The orthopaedic resident's work day begins at 6:30 am and usually ends around 4:30 pm. On Mondays radiology conference takes place from 4:00-5:00 pm; a didactic teaching session begins at 5:00 pm and ends at 8:00 pm. On Tuesdays there is an In-Training Exam review session that begins at 6:00 pm and ends at 8:00 pm (July-October).
Junior residents (PGY 2 and PGY 3) have every other weekend completely free of clinical responsibilities. The weekends they are on-call, one weekend they are on Friday and Sunday, and the other weekend they are on Saturday.

The senior residents (PGY 4 and PGY 5) are on backup call from home every third weekend. They come in as needed.

Hospital rounds begin at 6:30 am on the weekends and usually over by 8:30 am. At the end of hospital rounds, the post-call resident is free until 7:30 am the next morning.

Junior residents take call from home and are rarely in the hospital for 24 hours without a rest period – if they are, they get at least a 10-hour time period for rest and personal activities.

**On-Call Activities**

The objective of on-call activities is to provide the resident with continuity of patient care experience and management of emergencies throughout a 24-hour period. Orthopaedic residents do not take in-house call.

Junior orthopaedic surgery residents are typically on-call every fourth night. Call begins at 4:30 pm.

Continuous on-site duty must not exceed 24 consecutive hours. No new patients may be accepted after 24 hours of continuous duty except in outpatient clinics. A new patient is defined as any patient for whom the resident has not previously provided care.

All orthopaedic residents take at-home call (pager call):

At home call (pager call) is every fourth night for junior residents (PGY 2 and PGY 3) and every third or fourth night for senior residents (PGY 4 and PGY 5). Senior residents are on backup call.

When residents are called into the hospital from home, the hours the resident spends in-house are counted toward the 80-hour limit. The program director and the faculty members monitor the demands of call on the residents on a daily basis. Because of the small size of this program, the residents have almost continuous faculty contact. Scheduling adjustments are made as necessary to mitigate excessive service demands and/or fatigue.

**PGY 1 Resident Job Description**

**Job Duties**

**Clinical Diagnosis Management:**

The resident performs and documents a history and physical exam. Performs differential diagnosis. Develops and documents pre- and post-op care treatment plans. Develops and documents fluid and electrolyte therapy. Orders transfusions of blood and blood products.

**Clinical Non-Invasive Management:**

**Clinical Invasive (Operative Management):**

**Required Supervision:**
*Requires supervision by a teaching (faculty) physician or upper level resident determined by individual resident level of competence and difficulty of procedures.

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**PGY 2 and 3 Resident Job Description**

**Resident Level of Training: PGY 2 and 3**

**Job Duties**

**Clinical Diagnosis Management:**

**Clinical Non-Invasive Management:**

**Clinical Invasive (Operative Management):**

**Required Supervision:**
*Requires supervision by a teaching (faculty) physician or upper level resident determined by individual resident level of competence and difficulty of the procedures.

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**PGY 4 and 5 Resident Job Description**

**Resident Level of Training: PGY 4 and 5**

**Job Duties**

**Clinical Diagnosis Management:**

**Clinical Non-Invasive Management:**

**Clinical Invasive (Operative Management):**

**Required Supervision:**
*Requires supervision by a teaching (faculty) physician or upper level resident determined by individual resident level of competence and difficulty of the procedures.

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**Research Requirements for Residents**

The goal of a research project is to allow residents to learn how to develop an adequate hypothesis, develop and understand what constitutes a well-designed scientific study and learn how to interpret the use of statistics. During this project, residents, with the assistance of a faculty mentor, will develop a well designed hypothesis, develop a method to adequately test the hypothesis and learn what statistical methods work best in establishing the validity of the study. Residents will learn about the strengths and potential pitfalls of statistical analysis. Residents will learn how to better interpret the literature. By performing their own study, residents will be better able to understand and interpret the quality of the literature.

1. Each resident is required to perform at least one research project during his or her residency. The research project should be one of his or her design. In order to successfully complete the residency in orthopaedics, the resident must have completed the study and presented their study at a national or local meeting and submitted it to a peer reviewed journal for publication.

2. Consultation with a faculty mentor (either a clinical attending or the department Ph.D.) is required prior to implementation of the project

3. Residents are encouraged to do more than one project during their residency. Preferably one basic science project and one clinical project.

4. The project should be completed along the following timeline.

   a. By the end of September of the PGY 2 year, each resident will have picked a faculty mentor and a potential project.
b. By February of the PGY 2 year, each resident will have completed a literature review, and developed a hypothesis to be tested. The literature and hypothesis should be discussed with the faculty mentor.

c. By the completion of the PGY 2 year, a research protocol should be developed and data should begin being collected.

d. Data is collected during the PGY 2, PGY 3, and PGY 4 year. By the completion of the PGY 4 year the data collection should be complete and data analysis should be begun.

e. An abstract that can be submitted for presentation should be completed by the end of the PGY 4 year.

f. The completed paper should be finished by the end of the first 6 months of the PGY 5 year.

g. Completed papers will be presented at a Resident Research Reports, Grand Rounds.

5. Every 6 months residents will be required to give a 15 minute update of their project at the Monday afternoon research conference.

6. It is the responsibility of the faculty mentor and the resident to make certain the timeline for the research project is met.

7. Funding is available through various sources but residents are encouraged to apply for competitive grants to get experience with grant writing.

8. Support is available within the department from:
   - Carmen May, CRNP
   - Josalyn Lofton, Nurse Case Manager
   - Research fellows and Research Assistant
   - Faculty mentors
   - Secretarial staff

NOTES:
Resident Responsibilities for
Emergency Room, Trauma Coverage and Inpatient Consults

1. From 7:00 am until 4:30 pm all Emergency Department trauma consults and inpatient consults from USAMC and Knollwood Hospital should be referred to the junior resident on the orthopaedic trauma service. All Emergency Department trauma consults and inpatient consults from Children's and Women's Hospital should be referred to the resident on the pediatric orthopaedic service.

2. If either the junior resident on the trauma service or the pediatric orthopaedic resident is unavailable to see the patient, he/she should take the call, get the information, and contact another orthopaedic resident who is available. For example: On Tuesdays and Thursdays, the sports medicine resident is at Knollwood Hospital. If a consult at Knollwood Hospital comes in on those days, and the trauma resident is unavailable because of surgery or duties at USAMC, it would be appropriate for the trauma resident to call the sports medicine resident and ask him/her to see the consult.

3. If the problem is routine and the junior resident is experienced and comfortable handling the problem, he/she may do so. He/she should notify his/her chief resident and attending at a convenient time. If the problem is complex or the junior resident is uncomfortable handling the problem, he/she should contact either the chief trauma resident of the chief resident on-call for the day.

4. After 4:30 pm, all Emergency Department trauma consults and inpatient consults should be referred to the junior orthopaedic resident on-call. If the problem is routine and the junior orthopaedic resident on-call is experienced and comfortable handling the problem, he/she may do so. If the problem is complex or the junior resident is uncomfortable handling the problem, he/she should contact either the chief trauma resident or the chief resident on-call for the day.

5. For any level-one trauma, the junior resident should notify the chief orthopaedic trauma resident or the chief resident on-call immediately. Both should evaluate the patient immediately.
6. If the junior resident is more than an hour behind schedule seeing Emergency Room consults, the chief resident on-call should be notified and come in and assist.

7. Attending coverage: During the day there is an attending orthopaedic surgeon on-call from 7:00 am until 4:30 pm. The attending on-call for the day is listed in the table below. After 4:30 pm the attending on-call is listed on the call schedule.

<table>
<thead>
<tr>
<th>Attending Coverage</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>7am-12 Noon</td>
<td>Madanagopal</td>
<td>Meyer</td>
<td>Madanagopal</td>
<td>Madanagopal</td>
<td>Attending on weekend call</td>
</tr>
<tr>
<td>12 Noon-4:30pm</td>
<td>Madanagopal</td>
<td>Meyer</td>
<td>Madanagopal</td>
<td>Madanagopal</td>
<td>Attending on weekend call</td>
</tr>
</tbody>
</table>

8. No patient should ever be taken to the operating room without notifying the attending surgeon on-call.

9. The attending surgeon on-call should be notified on all level-one trauma consults.

10. The attending surgeon on-call should be called for all admissions.

11. If the junior resident or the chief resident is not comfortable with a problem, the attending surgeon should be called. Otherwise, routine consults can be presented to the attending the next day.

**Rounds and Routine Patient Calls**

1. Each attending is responsible for his/her patients.

2. If there is a problem with a patient for which an attending is responsible, he/she should be notified.

3. The trauma team residents and hand residents round at USAMC Monday - Friday.

4. The pediatric orthopaedic resident rounds at Children's and Women's Hospital Monday - Friday.

5. The sports medicine resident rounds at Knollwood Hospital Monday - Friday.

6. The hand resident rounds at USAMC Monday and Tuesday, and at Knollwood Hospital on Wednesday, Thursday, and Friday.

7. On Saturday and Sunday, rounds are to be made by the residents coming off-call and the incoming on-call residents.

8. Attending orthopaedists will be responsible for unassigned patients as follows:

   - USAMC - Dr. Madanagopal
   - Children's & Women's - Dr. Nimityongskul
   - Knollwood Hospital - Dr. Pearsall
8. If residents have any questions or concerns about patient management they should contact the attending responsible for the patient or the attending on-call.

9. If any problems occur with a patient, the responsible attending should be notified.
   - It is the responsibility of each attending to let the residents know how and when they want to be notified of problems.
   - Dr. Pearsall prefers to be called anytime one of his patients is having a problem.
   - Dr. Meyer wants to be called anytime one of his patients is having a serious problem either medically or politically (i.e., a difficult patient). For routine problems, Dr. Meyer can be notified the next day.

10. From 7:00 am until 4:30 pm, routine patient care phone calls should be handled by the resident on the appropriate service (i.e., hand patient calls should be referred to the hand resident; pediatric patient calls should be referred to the pediatric orthopaedic resident; USAMC or trauma patient calls should be referred to trauma resident).

11. After 4:30 pm, routine phone calls should be referred to the junior resident on-call.

12. No prescriptions for narcotics are to be refilled after hours or on weekends.

**Resident Supervision**

All patient care is the responsibility of, and must be supervised by, the appropriate faculty member as explained below:

1. Residents must be able to obtain consultation with, or help from, supervising faculty members, reliably and rapidly. If there are any difficulties in contacting the appropriate faculty member, contact Dr. Meyer.

2. Unless there is a PGY 1 resident on the service, the junior orthopaedic resident (PGY 2 or PGY 3) should be the first physician to see and evaluate the patient – except for level one trauma consults in the emergency department.

3. After evaluating the patient, the junior orthopaedic resident should order appropriate studies and develop a recommended treatment plan.

4. After reviewing the x-rays, the junior orthopaedic resident should present his/her work-up and treatment plan to the chief resident.

5. After the chief resident has reviewed the junior resident's work-up and plan, the attending physician on-call should be notified, if necessary.

6. A patient should NEVER be taken to the operating room without notifying the attending physician on-call.

7. If there is a PGY 1 resident on the service, he/she should be called first. He/she should see and evaluate the patient, order appropriate studies and formulate a treatment plan. The patient
should then be presented to the PGY 2 or PGY 3 orthopaedic resident on-call. The patient is then presented to the chief resident on-call.

8. A PGY 1 resident should NEVER be on-call by him/herself. There should always be a PGY 2 or PGY 3 on with the PGY 1.

9. Whenever possible, the PGY 1 should be on-call with a PGY 3, particularly during the first six months of the academic year.

10. The chief resident should always be available to come in and assist the junior resident on-call if they are getting too far behind (greater than one hour) on emergency department consults. This is particularly true during July and August of the academic year.

11. If, for any reason, the on-call attending physician cannot be reached, Dr. Meyer should be called.

12. Call schedules are published monthly.

13. Lists of pager, cellular, and home phone numbers for each of the residents and attendings can be obtained from Ms. Gail Driver or Ms. Molly Johnson in the Chairman’s office. After hours, the numbers can be obtained from the hospital operator.
Hand Surgery Service  
Goals and Objectives  

**Level of Resident:** PGY 3  
**Duration of Rotation:** 2/3-month rotations  

**Goals: PGY 3**  
During this rotation the resident will focus on developing proficiencies in the diagnosis and management of more complex hand problems. These problems include but are not limited to evaluation and management of the rheumatoid hand, congenital hand abnormalities, soft tissue coverage for the hand, and replantation.

The resident will develop the surgical skills necessary to treat more complex hand ailments such as Dupuytren’s contracture, cubital tunnel release and carpal instability. In addition, they will learn wrist arthroscopy including techniques of arthroscopic repair. They will also learn how to manage rehabilitation of hand ailments and how to prescribe appropriate splinting and rehabilitative modalities and techniques.

It is the responsibility of the PGY 3 resident to provide guidance to the PGY 2 resident to assist them in developing their skills.

**Topics covered during the rotation:**
- Hand biomechanics
- Hand and elbow fractures
- Avascular necrosis of the carpus
- Nail bed and fingertip injuries
- Scaphoid and other carpal fractures
- Replantation – indications and options
- Triangular fibrocartilage complex
- Flexor and extensor tendon injuries
- Soft-tissue coverage of the hand and forearm
- Dupuytren’s disease
- Carpal instabilities
- Brachial plexus injuries
- Infections
- Amputations and prosthesis
- Ulnar sided wrist pain
- Peripheral nerve injuries
- Rheumatoid hand problems

**Reading List for Hand Surgery Service:**
- Hand Surgery Update – American Society for Surgery of the Hand (AAOS)
- Green’s Operative Hand Surgery
- Surgical Exposures in Orthopaedics - Hoppenfeld

Clinical responsibilities for residents on the Hand service  
Location: 2 Medical Park office on Wednesdays and Fridays
- Evaluate clinic patients.
- Request x-ray(s) or other appropriate lab work and investigations.
- Formulate plan of treatment.
- Discuss all patients with attending physician and have attending physician see all patients before sign-off.

**Pediatric Orthopaedic Service**

**Goals & Objectives**

**Level of Resident:** PGY 3  
**Duration of Rotation:** 2/3-month rotations

To begin, residents should have knowledge, make diagnosis, assess and manage early phase, and carry on the non-operative aspect of treatment of the following conditions:

1. **Congenital and developmental conditions:** included in this category are:
   - DDH
   - Blount’s disease
   - Club foot
   - Scoliosis
   - Brachial plexus palsy
   - Neuromuscular conditions, i.e., CP and myelomeningocele
   - Scheuermann’s kyphosis
   - Fibula and tibial hemimelia
   - Proximal focal femoral deficiency
   - Radial club hand
   - Sprengel deformities
   - Some types on congenital scoliosis, etc.

   After gaining experience, residents who feel confident and capable may also manage these conditions operatively under the supervision of an attending physician.

2. **Genetic/Metabolic conditions:** included in this category are:
   a. Common forms of dwarfism
   b. Common forms of nutritional and renal rickets
   c. Osteogenesis imperfecta
   d. Osteopetrosis
   e. Etc.

3. **The third group of conditions** where residents are expected to be able to make the diagnosis and assessment and carry on the initial management and make appropriate consultation or referral are as follows:
   a. Osteogenesis imperfecta
   b. Fibrosarcoma, etc.
   c. Severe congenital kyphosis or kyphoscoliosis
   d. Severe forms of neuromuscular scoliosis
   e. Muscular Dystrophy.
   f. Severe forms of leg length discrepancy
g. Untreated cases of congenital hip dislocation in the walking age
h. Cases of neuromuscular hip dislocation, i.e., CP and myelomeningocele that have been dislocated of have had previous multiple procedures
i. Complex club foot and foot deformities in arthrogryposis

In summary, residents should have knowledge and be able to make a diagnosis in practically all conditions and to give definitive treatment in most cases of trauma and infection and benign bone tumors.

Residents participating in this rotation are expected to clearly develop and gain the knowledge and proficiency required to make an accurate diagnosis in practically all pediatric orthopaedic conditions. In addition, the resident should be able to give definitive treatment in most cases of pediatric orthopaedic trauma and infection and benign bone tumors.

Overall, definitive treatment in more complex pediatric orthopaedic conditions and problems depends on each individual’s exposures and experiences, which could vary a great deal. However, when dealing with such situations, one should be conscientious, honest, and always remind ourselves to “do no harm.”

**Pediatric Orthopaedic Service Guidelines**

Hospital Activities: USA Children’s & Women’s Hospital

1. Daily rounds on all in-patients (pre- and post-op) all consults, all Floors, PICU and NICU.
2. Respond to emergency consults from ER during working hours 7:30 am – 4:30 pm, Monday – Friday (on-call resident after working hours).

Operating Room: USA Children’s & Women’s Hospital
- Pre-op work ups.
- Participate in all surgeries.
- Post-op orders and care.

Clinic Activities (2 Medical Park) Monday (mornings) and Thursday (mornings and afternoons)
- Evaluate clinic patients.
- Request x-ray(s) or other appropriate lab work and investigations.
- Formulate plan of treatment.
- Discuss all patients with attending physician and have attending physician see all patients before sign-off.
ORTHOPEDIC TRAUMA AND RECONSTRUCTIVE SURGERY
PROTOCOLS FOR RESIDENTS
PGY 2 Residents 3/2-month rotations
PGY 5 Residents 2/3-month rotations

Residents’ Guidelines

Emergency Room Consults

Always EXAMINE the patient before communicating to seniors about the patient. (All patients consulted by junior residents should be discussed with the senior residents before disposition)

1. Try to look at the X-RAY and classify the fracture with common classification used.

2. All open wounds should be well described in terms of size and contamination and damage to soft tissues (muscle, tendon, nerve, vessel and periosteum).

3. Always remember to check compartment pressure (clinically, not invasive) and distal neurovascular status.

4. When describing the patient to SENIOR RESIDENT please mention the following to help determine the further management:
   a. Age, sex, height and weight.
   b. Dominant extremity if applicable.
   c. Bony injuries, soft tissue injuries related to orthopedics.
   d. Other system injuries treated by other teams,
   e. Medical condition of the patient including the current status and co morbid conditions
   f. What does the patient do for living?
   g. Regarding the x-rays try to get at least 2 views of the fracture, include a joint above and below the fracture. Do not compromise on x-rays because many times the fractures are missed because of poor quality x-rays. Whenever appropriate further Imaging should be ordered after consulting the senior resident.
   h. Documentation in the ER should include the appropriate diagnosis, management given, and follow up instructions. This documentation should include the attending and resident physician’s names. Patient should have a copy of this information and be instructed to bring it to the clinic when followed up.

In-Patient Consults

1. To be seen by the resident on call, priority based on the situation. It should be discussed with the chief resident or the attending in charge. The consult sheet to be signed by the attending in charge within 24 hrs of consult.
2. The patient name and diagnosis should be placed in the consult list.
Franklin and Stanton Road Clinics
1. All patients seen at Stanton Road and/or Franklin Clinics should be discussed with chief resident or attending before disposition and documented in the chart.
2. The number of patients scheduled should be less than 50 in each clinic.

Medical Park 2 Clinic
1. All patients should be seen by attending and documented in the chart.
2. For all trauma patients: relevant x-rays to be ordered at the time of 6th week from the time of surgery except in special situations.
3. For all total knee patients: LSLE, Knee PA in 30 flexion, Lateral and skyline views to be ordered at the initial visit and post-op only at 6 weeks, 12 weeks, 6 months and yearly thereafter.
4. For all total hip patients: Pelvis AP, and then the affected hip AP and lateral views at the time of initial evaluation, and post-op only at 6 weeks, 12 weeks, 6 months and yearly thereafter.
5. Scheduling of surgeries to be coordinated between Ms. Angela Denton and chief resident.

Scheduling and Posting Sheet
When scheduling cases, I strongly recommend the chief resident to have a book or diary to plan all the trauma cases and to coordinate between 2 Medical Park clinic cases and in-patient cases. (If we do an external fixator for a pilon fracture today I expect the chief resident to anticipate removal of the fixators in 6-8 weeks and post them accordingly.)

Our main OR days are Wednesday and Thursday with at least 2 rooms blocked the whole day. I would prefer to do most of the cases these days and only emergencies on Monday and Friday.

Cases posted in OR should have a posting sheet. It should include the following information:
1. Patient Demographics such as age, sex weight, MR #, etc,
2. Surgical procedure anticipated
3. Scheduling date and time
4. Surgery duration time
5. Anesthesia preference, if applicable
6. Operative table- what kind, list one alternative if possible
7. Whether C-Arm required or not (in future computer navigation)
8. Position of patient during surgery and equipment to be used for that
9. Prep solution preference
10. Implants to be used including the name of the company
11. Instrumentation required, such as special clamps for reduction etc.,
   i. Whether blood transfusion is anticipated or cell saver anticipated
   j. Any allograft tissue required including bone graft substitute.
Make sure the posting sheet is complete - following it through will be senior resident’s responsibility.

**Operating Room**

1. All operating room personnel must be treated with respect. Berating the staff will not be tolerated. We should behave as professionals.
2. Operative cases begin promptly at 07:30 am. Residents who wish to participate in surgeries are expected to be ready to operate at 07:15 am. Failure to arrive on time will limit operative experiences.
3. All operative patients should be discussed with the appropriate Attending along with the imaging studies for pre-op planning.
4. All operative trauma patients should have clearance from General trauma team and C-spine cleared whenever appropriate. It should be documented in the chart.
5. Whenever a case is posted for surgery, please indicate the appropriate implants along with the company name (i.e., tibial interlocking nail, Howmedica) to be used including the instrumentation (such as any special reduction clamps to be used, etc) required in the posting sheet. This should be senior resident’s responsibility. The availability of the implants should be checked well before the case starts.
6. I highly recommend that residents check the OR set up before the patient is taken in to the operating room. Check the OR table, C-arm, and make sure the Radiology tech is in the room when we drape the patient.
7. There should be less time wasted in the OR and should be very efficient if we try to adhere to the following guidelines. It may help reduce time make us more efficient!
   a. Make sure the patient is “in holding” at least 30 minutes before the start time. Complete all paperwork before this (consent, pre op note and checking the clearance and labs).
   b. One resident should check the OR set up - including the instrumentation.
   c. Resident should accompany the patient into the room.
   d. Once the patient is in the room, while the anesthesia is being administered the residents should get ready in terms of lead apron, make sure the C-arm tech is called, and the prep table is ready. Appropriate x-rays are put up. Assisting resident should be scrubbing now.
   e. Once the patient is induced, the operating resident positions the patient.
   f. The assisting resident who is scrubbed always wears two pairs of gloves and starts prepping the area with beta scrub as an OR assistant holds the limb. Then the area is dried with sterile towels. Then the area is painted or sprayed with betadine. In the mean time the operating resident is scrubbed and gowned.
   g. Now the assisting resident removes the outer gloves and helps the operating resident to drape the patient. Once the patient is draped the assisting resident removes the gloves and is gowned. In the meantime the operating resident marks the incision and is ready to go.
   h. During surgery it is best for the residents to concentrate on the surgery rather than talk about other cases or social events. This distracts other surgeons and the surgery tech.
   i. When closing the wound, remember to send for the next patient.
j. Always get the final x-rays in the OR before patient recovers from anesthesia. The back table should be kept sterile until the final x-rays are examined.
k. Always retrospectively check the time taken for the positioning, prepping, performing the surgery, and room turnover between patients. This will make us think and make changes to make it more efficient.
l. Regarding dictation, the operating resident dictates the operative report within the same day. The diagnosis and the procedure performed should be dictated as on the Green Card, including the CPT codes. This helps the Billing Dept. and also helps you when logging your cases.

8. Concept of quick time. This is especially for cases which need external fixator removal and application of cast. These cases can be done under short GA or mask. They do not require OR turnover (such as cleaning or set up of instrumentation). Patients do not require transfer to OR table and the procedure can be performed on the stretcher. Ideally 3 to 5 patients who require such procedures are posted on the same day and are sent home the same day. Usually these patients require some sort of brace or custom orthoses after removal of fixators. The orthotic people (e.g. Hanger) should be called and arrange to be present in the OR for taking a casting of the extremity.

9. Prophylactic antibiotics should be given for all cases 1/2 hr to 1 hr before incision. Except in cases where infection is suspected, the antibiotics are given after the samples for culture are taken.

**Rounds**
1. The chief resident is responsible for rounds and the management of the patients.
2. The chief resident and the junior resident should see every patient on morning rounds together.
3. Rounds are to be completed in a timely fashion to allow for arrival in the operating room at 07:15 am.
4. Medical students should not round and write in a patient’s chart without a resident’s supervision.
5. Patients that are possible “add-ons” should be kept NPO.
6. Secondary surveys should be performed for all patients.
7. In trauma service, please keep all the inpatients x-rays- both injury films and post op with the team (x-ray board) - until discharge and then return to Radiology.

1. All Post op patients should have clear plan regarding
   a. Weight bearing status
   b. Use of any brace or support
   c. Physical therapy instructions and if applicable any precautions
   d. DVT prophylaxis
   e. Pain management

   f. Antibiotics when appropriate
   g. Follow up schedule
   (All these should be well-documented in the chart and discharge summary.)
2. The trauma team including the attending will review all x-rays on the x-ray board on every single inpatient at least twice a week. Preferably on Monday and Thursday afternoon.

3. Wound checks are usually done on POD #2 but if the patient is discharged before POD #2 then wound check and dressing to be changed on POD #1.

4. Discharge summaries should be dictated within a day or two and should be available when the patient comes for follow up visit.

Follow up schedule for most (not all) patients are 2 weeks post op for wound check, no need for x-rays during this visit (appropriate x-rays for the next visit should be mentioned in your plan).

6 weeks post op with x-rays, 12 weeks post op with x-rays, 6 months and 12 months with x-rays. Then yearly follow up with x-rays.

**Compound Fractures:**

**Grade I:** Place a diluted betadine soaked gauze piece on top of the wound after gently washing the wound with sterile normal saline. Do not push the saline into the wound using syringe or any other device. Do not explore the wound in ER. Do not reduce the bone spike, which is protruding through the skin into the wound in ER. (Unless you think the skin may be necroses, then make sure the bone piece, which is pushed inside, does not have any foreign body or dirt.)

This situation does not apply to compound dislocation where reduction of dislocation is important. Patient should be taken to OR and wound debrided when the fracture is managed. Wound debridement should not be delayed beyond 12 hrs from the time of injury.

If the wound is over a knee or ankle joint (superficial joints), saline injection test can be done under sterile precaution to rule out joint involvement but no aggressive probing of the wound to be done in ER. If any suspicion patient should be taken to operating room and explored under sterile precaution

Potential antibiotics to be started in ER and is usually cefazolin 1gm q 8hrs till wound is epitheliasied.

**Grade II:** Gentle wash of the wound in the ER with sterile saline up to 3 liters. Place a diluted betadine soaked gauze piece on top of the wound. Appropriate splinting to be done. Wound to be debrided before 12 hrs from the time of injury. Most of the long bones can be primarily nailed. Arrange for antibiotic bead chain, (6mm Tobramycin) for the wound. Generally the wound is primarily closed over the beads. Once the wound is primarily closed, the wound is checked on the Floor for any evidence of infection or inflammation. If the wound cannot be closed, then external fixator with antibiotic bead pouch technique will be employed. The bead pouch is changed on alternate days in OR and closure attempted within 6 days at which point ORIF done with appropriate implants.
Parenteral antibiotics to be started in ER and is usually cefazolin 1gm q 8 hrs till epitheliasisation with tobramycin 80mg q 12hrs for 3 days. (This may change as we are enrolling patients in antibiotic bead study)

**Grade III:** Most will be initially managed with external fixators with antibiotic bead pouch technique. If the wound can be primarily closed, it will be attempted as soon as possible. If the wound cannot be closed primarily, then plastic surgery should be involved early and attempt made to close the wound within a week. Wound vac dressing along with antibiotic beads can be used until then.

ORIF done at the time of wound closure or earlier. Soft tissue reconstruction will be planned with the help of plastic surgery.

Parenteral antibiotics same as Gr II, third antibiotic is added when the wound is heavily soiled usually it is penicillin.

**Management of External fixators:**

1. Pin tracts to be cleaned twice daily with diluted hydrogen peroxide and then with saline. Then the pin tracts are dried and a sterile gauze piece to be wrapped around it.
2. All patients should be taking oral antibiotics until the fixator is removed. First choice is Bactrim DS po qd, if allergic to sulfalevoquin at 500mg po qd or keflex at 500 mg po bid can be used.
3. All fixators are to be removed within 8 weeks of application and changed to either a cast or brace appropriately. Removal to be scheduled as quick time as described earlier.
4. Superficial pin tract infections are managed by aggressive cleaning protocol and change in antibiotics. Deep pin tract infection by removal and change of pins along with antibiotics.
5. All lower extremity fixators not spanning the ankle should have foot plate to prevent equinus (plantar flexion) deformity.

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**Spine Service**

**Goals & Objectives**

**Length of Rotation:** 3 months

**Level of Resident Training:** PGY 4 and PGY 5
For the senior level and chief residents, the rotation should focus on developing proficiencies on the clinical and radiographic assessment of the spine and following spine trauma.

Besides making the diagnosis, the resident should also be able to formulate various treatment options including surgical treatment of various spine ailments. The resident should be competent in the initial evaluation of patients following spine trauma, initiating treatment, and formulating treatment plan with the attending physicians.

The resident should be competent in surgical skills on various exposures of the spine, including cervical exposures, fusion of the lumbar and cervical spine, instrumentation at various vertebral levels and decompression of nerve roots.

**Topics to be covered on the Spine Service:**

- Spine anatomy
- Biomechanics of the spine
- Imaging studies of the spine
- Spondylolisthesis – various types and difference in natural history
- Cervical degenerative disease
- Thoracic disc herniation
- Disc herniations
- Low back pain
- Sciatica
- Lumbar degenerative disease
- Pediatric and adult scoliosis
- Spine trauma
- Central, anterior, posterior cord syndrome, Brown-Sequard syndrome
- Tumors of the spine
- Rheumatoid spine
- Degenerative spine disease – DISH, ankylosing spondylitis
- Spine tumors
- Outcomes of spine surgeries

**Reading list:**

1. Orthopaedic Knowledge Update – Spine
2. Orthopaedic Knowledge Update 8
3. Spine – Rothman and Simeone
4. Adult spine: Principles and Practice – Frymoyer
5. Surgical Exposures in Orthopaedics - Hoppenfeld
Sports Medicine Service
Goals and Objectives

Length of Rotation: 2/3-month rotations
Level of Resident Training: PGY 4

For senior residents, this rotation should focus on developing proficiencies on the diagnostic and treatment of various sports medicine ailments. They should be able to undertake more
complicated diagnoses such as shoulder instability, multi-ligament injured knees, osteochondral lesions in the ankle, etc.

The resident should be competent in surgical skills involving arthroscopy of various joints. They should also develop certain proficiency in performing higher-level surgical procedures, such as arthroscopic acromioplasty, distal clavicle resection, arthroscopic lateral releases, and ACL reconstruction. They should improve both arthroscopic and open surgical skills as they pertain to the shoulder, elbow, knee, and ankle. Diagnostic ankle arthroscopy and elbow arthroscopies are also surgical procedures that may be mastered by the skilled senior resident. Residents should also develop skills in joint injection and aspiration.

Residents should be able to interpret radiographs and MRI’s of the upper and lower extremities in the assessment and treatment of orthopaedic degenerative and sports-related diseases. They should improve both arthroscopic and open surgical skills as they pertain to the shoulder, elbow, knee, and ankle.

**Topics to be covered during the rotation:**

- Biomechanics of ligaments
- Shoulder and knee biomechanics
- Common elbow pathology, including ligament insufficiency, overuse syndrome
- Knee ligament reconstruction, ACL, MCL, PCL, PLC, and multi-ligament injured knees
- Meniscal pathology
- Osteochondral defects – classification and treatment
- Patellofemoral disorders and treatment
- Stress fractures
- Ankle sprain and its management
- Overuse syndrome and various tendonopathies
- Rotator cuff pathology
- Acromioclavicular joint pathology
- Impingement syndrome
- Shoulder instability and treatment
- Management of athletes both on and off the playing field
- Sports injuries in the pediatric population

**Reading list:**

1. Orthopaedic Knowledge Update – Sports Medicine 2
2. Orthopaedic Knowledge Update – Shoulder and Elbow
3. Orthopaedic Knowledge Update 8
4. Knee Surgery – Fu, Harner
5. Review of Sports Medicine and Arthroscopy – Miller
6. The Hughston Clinic – Sports Medicine Book – Baker
7. Surgical Exposures in Orthopaedics – Hoppenfeld
Sports Medicine Service Guidelines

1. Report to all sports medicine clinics on time or notify staff prior to clinic and make arrangements for back-up coverage.
2. Assist with seeing patients in clinic and dictating clinic notes. (Be familiar with data collection forms.)
3. Attend all scheduled sports medicine surgeries or make appropriate arrangements for back-up coverage.
4. Speak with sports medicine nurses prior to rotation regarding paperwork completion that is necessary on the rotation.
5. Perform history and physical in clinic for patients scheduled for surgery
6. Assure that appropriate radiographs are available the day of surgery.
7. Collect all studies for surgeries during the week prior to the case. Each Monday, the resident will discuss each case with Dr. Pearsall, including any templating as well as operative planning.
8. Pre-operative consultations are to be completed (including social service) for all in-patients prior to surgery.
9. Arrange to round each day on all in-patients at a set time with Dr. Pearsall until the patient is discharged.
10. Based upon pre-operative plan, follow-up on necessary measures to ensure that they are completed (nursing care, physical therapy, etc.).
11. Notify Dr. Pearsall regarding any problems or questions.

Sports Medicine Rotation Dictation Requirements

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Indications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Hospital #</td>
<td>- nature of illness</td>
</tr>
<tr>
<td>Attending MD Name</td>
<td>- previous conservative treatment</td>
</tr>
<tr>
<td>Date of Dictation</td>
<td>- pre-operative tests</td>
</tr>
<tr>
<td>Patient Sex</td>
<td>- pre-operative assessment</td>
</tr>
<tr>
<td>Patient Age</td>
<td>- discussion of risks with family</td>
</tr>
<tr>
<td>Anesthesia Type</td>
<td>Procedure:</td>
</tr>
<tr>
<td>Blood Loss</td>
<td>- positioning</td>
</tr>
<tr>
<td>Fluids</td>
<td>- pre-operative Abx given</td>
</tr>
<tr>
<td>Urinary Output</td>
<td>- tourniquet time</td>
</tr>
<tr>
<td></td>
<td>- procedure</td>
</tr>
</tbody>
</table>
Drains (location) | - dressings/equipment (brace, etc.)
--- | ---
Dr. Pearsall was present for critical portion of case.
Disposition/Instructions

**Total Joint Service**

**Goals and Objectives**

**Length of Rotation:** 3 months  
**Level of Resident Training:** PGY 5

For the senior resident, the rotation should focus on developing proficiencies on the diagnostic and treatment of hip and knee arthritis. They should be able to identify and analyze more complicated problems such as revision total hip and knee arthroplasty, painful joint arthroplasty, infected arthroplasty, and osteotomies.

The resident should be competent in surgical skills involving primary total hip and knee arthroplasty. They should also be competent in high tibial osteotomy and other hip osteotomy procedures. During the rotation, the resident should develop a protocol in how to handle revision joint arthroplasty, e.g., the need for a revision system, the need for reconstructive cages, structural bone grafts, and tumor prosthesis.

**Topics to be covered during the rotation:**

- Knee biomechanics
- Hip biomechanics
- Viscosupplementation
- Primary total knee replacement – pre-operative planning
- Primary total hip replacement – pre-operative planning
- Templating
- Revision total knee replacement
- Revision total hip replacement
- Periprosthetic fractures
- Infected joint arthroplasty
- High tibial osteotomy
- Valgus osteotomy of the hip
- Avascular necrosis of the hip – treatment options
- DVT prophylaxis following joint replacement
- Rheumatoid arthritis
- Unicondylar knee replacement

Reading list:

1. Orthopaedic Knowledge Update – Hip and Knee reconstruction
2. Knee Surgery – Fu, Harner
3. The Adult Hip – Callaghan
4. Surgical Exposures in Orthopaedics - Hoppenfeld

**PGY 4 Resident Foot and Ankle Rotation**

Orthopaedic Specialists of Alabama, P.C.
Baptist Montclair Hospital and HealthSouth Medical Center
Birmingham, AL

Each PGY 4 resident participates in a three-month rotation under the direction of Dr. John Gould in Birmingham, AL. The first rotation extends January 1 – March 31; the second rotation extends April 1 – June 30.

Alabama State medical licensure is required: Alabama Controlled Substance license is desirable but not required. Fully furnished apartment/housing is paid and provided through USA Department of Orthopaedic Surgery. Utility expenses incurred (with the exception of personal telephone calls and cable TV) are reimbursable expenses to the resident at the end of each rotation by submitting original paid receipts to residency coordinator.

John S. Gould, MD
Orthopaedic Specialists of Alabama, P.C.
720 Montclair Road, Suite 200
Office (205) 591-2516
[www.orthospesialist.com](http://www.orthospecialist.com)
Goals and Objectives
Foot and Ankle Rotation

1. Educational goals endeavor to enhance the resident’s learning and exposure in the curriculum of orthopaedic foot and ankle experiences.
2. The Orthopaedic Specialists of Alabama, P.C. desires to contribute to the educational preparation of the resident by making available additional clinical facilities that meet the recommendations of the JCAHO.
3. Residents will learn how to diagnose and treat diseases and injuries of the foot and ankle.
4. Residents will learn the indications for and appropriate techniques for surgery of the foot and ankle.
5. Residents will learn the appropriate use of and how to prescribe orthotics for diseases and injuries of the foot and ankle.
6. Allowing mutual growth and development of residents and medical staff at Orthopaedic Specialists of Alabama, P.C., every effort will be made to provide an environment that promotes insight into advantages and opportunities of instructors in clinical training settings and/or teaching institutions.

7. PGY 4 residents are encouraged to strengthen their abilities and participate in expanding the capabilities of Orthopaedic Specialists of Alabama, P.C. for training and expertise in rendering health care.
8. ASMI will strive to magnify residents’ exposure to a variety of (foot and ankle) cases and enhance the resident’s experience in patient care through direct involvement.
9. Through the opportunity to share knowledge, our goals serve to improve programs at Orthopaedic Specialists of Alabama, P.C. and USAMC. Such exchanges allow significant advances in resident training and patient care.
General Program Information

Orthopaedic Surgery residents are employees of the University of South Alabama Medical Center. USA Hospitals provide direct financial assistance to departments in support of resident education.

The House Staff Policy and Procedure Manual and the USAMC Staff Employee Handbook describe hospital rules, grievance and discipline actions, benefits, and services. The House Staff Policy and Procedure Manual are available on the University of South Alabama, College of Medicine website www.southalabama.edu/com/residency. Click on the Residency Benefits link for more information.

Alabama Medical Licensure
Residents are required to obtain an unrestricted Alabama license to practice medicine within seven months of completion of the minimum postgraduate training required for such a license. Upon receipt of license, a copy must be on file in the residency coordinator's office. State medical licenses expire yearly on December 31; the Orthopaedic Surgery Department does not pay for initial license, license renewal, or late fees.

Chairman’s Chat
The first Monday each month at 6:30 a.m. is reserved for Chairman’s Chat. Dr. Meyer meets with residents as a group to discuss current issues relating to resident activities, performance, and/or any other matters of importance. Residents also have the opportunity at this time to communicate any concerns or grievances.

Clinic Location
The Orthopaedic Surgery Clinic is located on the USA Knollwood Hospital campus: the address is 3421 Medical Park Drive, 2 Medical Park, Mobile, AL 36693. Orthopaedic surgery residents routinely see and treat patients with attending physicians at this location according to training assignments. Residents’ patient responsibilities in the clinic setting generally include, but are not limited to, patient history documentation, physical exam, clinic notes, injections, dictation, and billing codes.

Conduct and Appearance
The demeanor and personal appearance of the resident reflects quality, professionalism, and pride in all roles of the resident. In addition to the orthopaedic surgery resident’s skills and technical abilities, the manner in which he/she “presents” himself/herself to others is crucial in earning the confidence and respect that is particularly important in successful patient and professional relationships.

Your professional image and that of the USA Department of Orthopaedic Surgery is projected by your appearance. Denim jeans or sportswear of any type is never acceptable, nor are tennis shoes or shoes without socks. Male residents should wear clean and pressed shirt, tie, and slacks at all times when involved in patient care and/or in the clinic setting. Female residents should dress appropriately, in a similar manner, following the same guidelines. Scrubs are not acceptable attire for clinic setting and/or Grand Rounds.
**Educational Leave Policy**

Approval and financial support of Orthopaedic Surgery resident(s) attendance to professional meetings/seminars/workshops, etc. is generally at the discretion of the Department Chair. However, attendance to the following programs is required and fully sponsored by the Department:

- AO Basic Fracture Management or Zimmer Trauma Course for PGY 2s
- Seminar in Musculoskeletal Pathology for PGY 3s
- Orthotics and Prosthetics Course for one PGY 4 and one PGY 5
- Board Review Course for PGY 5s
- American Academy of Orthopaedic Surgeons for one PGY 4 and one PGY 5

**Evaluations**

The opportunity for residents to evaluate members of the faculty is offered at least twice yearly. Residents may complete evaluation forms anonymously. Results are reviewed by the Chairman.

Upon the completion of each 3-month rotation, the director of the rotation records his evaluation of the resident’s performance. The Chairman assesses each evaluation and meets privately with the resident to review his/her overall performance and/or to discuss areas of concern.

Residents are required to complete a Rotation Evaluation form upon completion of each 3-month rotation. These evaluations are also fully reviewed by the Chairman. Candid comments regarding the rotation’s strengths and weaknesses are encouraged.

Evaluation of the Residency Program by residents is conducted annually at the end of the academic year. Results are compiled and reviewed by the Chairman and faculty members and presented to Curriculum Committee.

**Family and Medical Leave**

A leave of absence without pay may be granted upon request to residents who are unable to work because of medical reasons or pregnancy-related conditions.

**Holidays**

There is no compensatory time for holidays worked by residents. There are no personal holidays.

**House Staff Office**

The House Staff office is located in room 611 of the Mastin Building at USA Medical Center. Employment paperwork, insurance, payroll, student loan deferments, etc. for every resident are handled through this office. The House Staff coordinator serves as a liaison between the residents and the hospital administration.

**Illegible Medication Orders**

The safeguard of patient care is essential to all representatives of USA hospitals and clinics. The Medication Use Committee and the Executive Committee of USAMC has endorsed the following policy:

1. The ordering physician must append the last four digits of his/her pager number to his/her signature on the order sheet.
2. The USAMC Pharmacy, through the Committee, will notify appropriate chiefs of service of those individuals who write an inordinately high number of illegible orders for medication. The chief of service then has the responsibility to work with the individual to reduce the potential for error in order transcriptions.

**Impaired Physician Policy**
It is recommended and in accordance with medical licensure requirements in the State of Alabama that residents utilize the Physician’s Recovery Network of the Medical Association of the State of Alabama if they need assistance for substance abuse or test positive in required drug screens.

**Physician’s Recovery Network**
Montgomery, AL       (334) 261-2044

**Lab Coats**
Three lab coats are issued at the beginning of the PGY 1 year. One coat is issued each academic year thereafter. It is the resident’s responsibility to keep lab coats clean and in good repair. Additional lab coats may be purchased at the time of order (usually March) at the prevailing hospital cost.

**Library**
The Biomedical Library is located on the 1st floor of the Mastin Building. It is accessible 24 hours a day, seven days a week. Patrons must display current, valid University identification to gain library entrance. Residents do not have the authority to “charge” library copy services, journal/article searches, or any other library services to the Department of Orthopaedic Surgery. A copy card is available from the House Staff office (Mastin 611). Please avoid involving department personnel in searches for misplaced books. Library books on loan to residents are the borrower’s responsibility.

**Loan Deferments**
The House Staff Coordinator, located in room 611, Mastin Building, can assist with the filing of paperwork necessary for the deferment of loans.

**Meal Allowance**
Residents receive a meal allowance of $5.00 per night on-call. Payment is included in the resident’s paycheck and is identified separately from salary. Residents also receive a 25% discount for food in hospital cafeterias.

**Medical Records**
Residents are required to complete medical charts on a timely basis. Records are considered delinquent if not completed within twenty (20) days following patient discharge. Completion of charts, before and after vacations, meetings, and away rotations helps to avoid delinquent medical record reports to the Chairman’s Office and consequently to departmental personnel files.

**Mileage Reimbursement**
Mileage between health care facilities (work-related) is reimbursable at 44.5 cents per mile. Requests for reimbursement of authorized in-state travel expenses should be submitted on the official in-state travel expense form. It must have the traveler’s signature in the certification space, be notarized, and signed by the Chief Resident. The destination, purpose of trip, and date should be clearly indicated. Residents will be reimbursed for the standard round-trip mileage.

**Mileage between USA Facilities (Round-trip)**

- Campus to Medical Center: 12 miles
- Campus to Spring Hill Avenue: 16 miles
- Campus to Knollwood Hospital: 13 miles
- Campus to Children’s & Women’s Hospital: 16 miles
- Medical Center to Knollwood Hospital: 22 miles
- Medical Center to Children’s & Women’s Hospital: 5 miles
- Spring Hill Avenue to Knollwood Hospital: 21 miles
- Spring Hill Avenue to Children’s & Women’s Hospital: 1 mile
- Knollwood Hospital to Children’s & Women’s Hospital: 22 miles

**Miscellaneous Round-trip mileage from Knollwood Hospital**

- Mobile Infirmary: 18 miles
- Providence Hospital: 14 miles
- Searcy Hospital/Clinic: 70 miles
- Thomas Hospital: 50 miles
- Mobile CRS: 18 miles
- Jackson CRS: 150 miles
- Selma CRS: 350 miles
- Birmingham, AL: 550 miles
- New Orleans, LA: 300 miles

**Moonlighting**

This program complies with all sponsoring institutional policy and procedure regarding moonlighting. Departmentally, because residency education is a full time endeavor, the program director monitors moonlighting carefully to ensure that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. In-house moonlighting is counted toward the 80-hour weekly limit of on-duty hours and is not permitted if it will result in exceeding the limit. Another determining factor for the effect moonlighting has on the resident’s educational experience is by monitoring in-training examination scores. Residents who do not exceed the 50th percentile on the in-training examination are not allowed to Moonlight.

**Operative Experience Reporting System**

The ACGME Resident Procedure Tracking System is an Internet-based system that utilizes CPT codes to categorize resident operative experiences. The use of this system by orthopaedic surgery residents is required by the ACGME. Residents may access the system through the Internet connection in the resident’s office (2 Medical Park) or from a home-based computer system with Microsoft’s Internet Explorer version 4.0 or higher. The system is user-friendly, requires minimum training time, and is accessed by an assigned password.
Orthopaedic In-Training Examination

The OITE is a compulsory examination: it is administered annually to all orthopaedic surgery residents registered in accredited residency training programs. Dr. Prasit Nimityongskul usually proctors the exam which is always held on the second Saturday in November. Strict rules and regulations govern the examination guaranteeing the security and validity of the test. Residents are relieved from all duties during the time of examination. Upon receipt of test results, the Chairman meets with residents individually to discuss the resident’s actual test score, and the percentile rank of that score relative to the national pool of residents who took the exam.

Pagers

Pagers and replacement batteries for residents are distributed through your orthopaedic residency coordinator’s office. Report pager malfunction or loss immediately to either the residency coordinator or departmental secretary!

Promotion and Dismissal

Educational and clinical performances are integral components of residency training and must be regarded as satisfactory for promotion to occur. Therefore, there is regular appraisal and review of resident performance for each rotation. This evaluation reflects close observation of each resident’s capabilities and competence as they compare with other residents at the same level of training.

In the event a resident’s performance in the educational and/or clinical program is unsatisfactory, the Chair of the Department will notify the resident, by hand-delivered or certified mail, of the deficiencies and the remedial action required to improve performance. If, in the opinion of the Chair, continued clinical/educational activities of the resident are not in the best interest of patient care, the resident may be temporarily relieved of clinical responsibilities. Residents may be reprimanded, placed on specific probation suspended or terminated for unsatisfactory performance and/or unacceptable conduct in carrying out clinical and educational responsibilities in the residency program. For suspension and/or termination, review and approval by the Department Chair and Vice President for Medical Affairs (or his designee) are required.

The resident has the right to appeal an adverse decision reached by the Chair of the Department before a hearing of the Chairs of the Clinical Departments. Request for an appeal must be made in writing to the Vice President for Medical Affairs within ten working days of the resident’s receipt in writing of the disciplinary action. During the hearing of an appeal, the resident will have the opportunity to appear and have individuals available to speak on his/her behalf. Please refer to the House Staff Manual for additional information: this Department adheres to the institutional guidelines and procedures in disciplinary actions and measures.

Relocation Allowance

A relocation/moving allowance of $2.00 per mile, up to $1200.00, is payable to residents entering our program through the Match. The resident is required to submit a standard mileage reimbursement form (based on mileage figures from the Rand McNally Atlas) through the residency coordinator’s office.
**Resident Files**
Departmental files are maintained for each resident. These files comprise the permanent record of the resident’s education and training experience. Inquiry responses, letters of recommendation, credentialing information, and other important facts and data are based on information contained in the departmental file.

House Staff personnel files are located in the office of Personnel Relations at USA Medical Center. These files reflect the historical account of the resident’s work record and contain all documents related to employment, i.e., written warnings, letters of resignation or termination, etc. The personnel file is available for review by the resident during regular business hours, as mandated by federal law. Educational records are not part of the House Staff personnel file.

**Resident Selection Process**
The USA Department of Orthopaedic Surgery selects from among eligible applicants without regard to gender, race, national origin, disability, or religious beliefs. Applications are reviewed on the basis of preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. In addition, we look for applicants we feel will make competent and compassionate orthopaedic surgeons.

This program fully participates and adheres to all rules and guidelines set forth by the National Resident Matching Program (NRMP).

**Residents as Teachers**
The opportunity for residents to provide a positive influence in medical student education is vitally important. As role models, residents should demonstrate focused and efficient patient care, teamwork, and raise critical teaching points to all medical students, particularly those rotating through our services.

**Request for Transfer/Resignation from the Residency Program**
Requests for transfer to another program either within the USA system or outside the USA system should be made to the Orthopaedic Surgery departmental Chair.

Resignation from your current residency position within the USA Department of Orthopaedic Surgery should be made known to the departmental Chair in writing no less than thirty (30) days prior to the effective date of resignation.

**Salary/Stipend**
Resident stipends are established and set each year by USA Medical Center. Paychecks are delivered bi-weekly to the resident’s mailbox at Medical Park 2, 2nd floor.

**Scrubs**
USA Hospitals does not maintain scrubs for resident physicians’ use. Residents will initially be issued five sets of scrubs but will be responsible for replacements thereafter. Policy will allow for residents to be issued scrubs in the event their personal scrubs become soiled. Additional scrubs may be purchased at the prevailing hospital cost.

**Sick Leave**
Upon employment and with each anniversary, each resident is granted 12 days paid sick leave per 12-month period. Sick leave does not accrue and is not cumulative. There is no remuneration for unused sick days.

**Social Activities**
Certain social and educational activities within and/or sponsored by the Department of Orthopaedic Surgery are not optional unless the resident is participating in an out-of-town rotation or the resident is on-call. Attendance to the following activities/events is required:
- Alabama Orthopaedic Society Meeting
- Southeastern Orthopaedic Foot Club Meeting
- Lewis D. Anderson Society Meeting
- Departmental Christmas Party
- Chief Resident’s Graduation Dinner

**Travel Requirements**
Out-of-town: Travel arrangements for orthopaedic surgery residents are generally made through the residency coordinator’s office. The USA College of Medicine requires completion of a *Request to be Absent from Work* form prior to travel. Please review the following guidelines:
- **Airline Reservations**: Springdale Travel is the official travel agency for the University of South Alabama. Travel insurance in the amount of $100,000.00 is provided for all University personnel traveling on tickets issued by Springdale Travel. (If any other travel agency is used to purchase airline tickets, reimbursement cannot be made until after the trip.) *Canceled tickets must be returned to the residency coordinator’s office.*
- **Hotel Accommodations**: Actual expenses for lodging cannot exceed the single occupancy rate. In the event that more than one resident is staying in the same room, reimbursement for double occupancy is allowed. Advance payment of lodging expenses is not allowed. *Hotel Receipt indicating name, address, telephone number of hotel, date(s), daily room charge, and number of occupants are required for reimbursement.*
- **Meals**: Actual (reasonable!) meal expenses (excluding alcoholic beverages) for each full day of travel is allowed. If your paid meeting registration included provision for one or more meals, the traveler should not claim any additional reimbursement for that meal. The traveler will not be reimbursed for taxi fares to and from meals. *Receipts containing name of restaurant, date, and actual meal expenses are required for reimbursements.*

**Vacation/Meeting Policy**
First and foremost, please be aware that ANY/ALL time spent away from assignments during your orthopaedic surgery residency training (for any reason) requires approval and documentation. This time away includes, *but is not limited to*, vacations, attendance to required and/or sponsored meetings, fellowship interviews, job interviews, etc. The proper forms, which are available in the Chief’s Office (2nd floor, Med Park 2) must be completed by the resident, submitted for approval of the administrative chief resident and then by the attending surgeon of the resident’s rotation/service. Once the administrative chief resident and the attending surgeon
have signed the appropriate form for the vacation/meeting the request form should be returned to Ms. Gail Driver. Ms. Driver will then forward the completed form to the department chairman for final approval.

Upon employment and with each anniversary, residents are granted four (4) weeks (20 working days) of paid vacation or leave per 12-month period. Vacation or leave cannot be carried over to subsequent years. There is no terminal pay for unused vacation or leave.

Residents are allowed to attend one meeting per year. The meetings are:
- PGY-2 year – The AO or OTA basic trauma course
- PGY-3 year – The Enneking pathology course
- PGY-4 year – One resident will attend the American Academy of Orthopaedics Annual Meeting and one resident will attend a prosthetics and orthotics course.
- PGY-5 year - One resident will attend the American Academy of Orthopaedics Annual Meeting and one resident will attend the prosthetics and orthotics course. In addition, residents in this year will also attend a review course for the American Board of Orthopaedic Surgery’s certifying examination.

Residents are required to attend the Southeastern Foot Club Meeting and the Alabama Orthopaedic Society Meeting. The exception being residents needed for call coverage.

Residents may be allowed to attend additional meetings throughout the year at the discretion of the department chairman.

Residents may attend any additional meetings they wish by using their vacation time and paying for the meeting themselves.

The following guidelines cover vacation or leave:
- No vacations are granted in the months of June or July.
- Special circumstances/situations will be considered by the chairman.
- No more than two residents should be absent for meetings or vacations concurrently. (This includes the resident rotating in Birmingham).
- No two residents at the same level (i.e. PGY-2/PGY-3 and PGY-4/PGY-5) should be absent for meetings or vacations concurrently. (This does not include the resident rotating in Birmingham).
- Residents should not take more than one week of vacation per quarter.
- Residents must take vacation in one-week blocks.
- Residents should not schedule meetings and/or vacations so they are gone 2 weeks consecutively.
- At least thirty (30) days advance notice is required for vacation or meeting approval.
- Vacation requests must be made in writing (forms are available in the Chief Residents office). They should first be approved by the administrative chief resident and then by the attending surgeon on the resident’s service. Once the administrative chief resident and the attending surgeon has signed off on the vacation or meeting, the request form should be given to Ms. Gail Driver. Ms. Driver will then forward the completed form to the department chairman for final approval.
In the event of conflicts, vacations and or meetings will be approved on the following priority basis:

1. Required meetings
2. Elective meetings
3. Vacation
4. If there is more than one request for vacation in the same time period, vacation will be approved on a first-come, first-served basis.

Do not make reservations or irreversible arrangements for vacations or meetings until you receive final approval in writing or you may wind up loosing your money!

Receipt for USA Department of Orthopaedic Surgery Resident Handbook

I, the undersigned, acknowledge receipt of the University of South Alabama Department of Orthopaedic Surgery Resident Handbook (revised January 2006).

I understand that I am required to read and become familiar with the contents of the Resident Handbook. I further understand that my Program Director will answer any questions regarding the contents of the Resident Handbook.

________________________________________
Printed Name

________________________________________
Signature Date