



## ANNUAL SUMMARY REPORT FORM

### PHILIPPINE BOARD OF ANESTHESIOLOGY

NAME OF HOSPITAL:		EMAIL:	LEVEL OF ACCREDITATION:
ADDRESS:		TELEPHONE NO.:	
		FAX:	
TOTAL BED CAPACITY:	PRIVATE:	ACCREDITED DEPARTMENTS:	
	SERVICE:		
		INTERNAL MEDICINE	<input type="checkbox"/> YES <input type="checkbox"/> NO
		OB-GYN	<input type="checkbox"/> YES <input type="checkbox"/> NO
		PEDIATRICS	<input type="checkbox"/> YES <input type="checkbox"/> NO
		SURGERY	<input type="checkbox"/> YES <input type="checkbox"/> NO

DEPARTMENT HEAD:			
	TERM:	FROM	TO
TRAINING OFFICER:			
	TERM:	FROM	TO

TOTAL NUMBER OF ANESTHESIA CONSULTANT STAFF:		TOTAL NO OF APPLICANTS FOR THE TRAINING PROGRAM 20____:	
FULL-TIME		TOTAL NO OF AVAILABLE POSITIONS FOR RESIDENTS 20____:	
PART-TIME		TOTAL NUMBER OF RESIDENTS	
VISITING			
TOTAL NUMBER OF FELLOWS:			

NUMBER OF RESIDENTS		AS OF DECEMBER 31, _____				
YEAR LEVEL	NO.	PROMOTED	RESIGNED	TRANSFERRED	TOOK EXTENDED LEAVE	REMARKS
I						
II						
III						

Does your hospital implement a structured rotation for residents across the different subspecialties?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>If yes, please attach a detailed clinical rotation schedule and indicate how much time (weeks) residents spend in each subspecialty.</i>	

**HOSPITAL CENSUS 20\_\_\_\_\_**

TOTAL NUMBER OF ADMITTED PATIENTS	
TOTAL NUMBER OF PATIENTS ADMITTED FOR SURGERY	
ELECTIVE	
EMERGENCY	
TOTAL NUMBER OF CASES PER SERVICE	
GENERAL SURGERY	
MINIMALLY INVASIVE	
OB-GYNE	
PEDIATRICS	
NEUROSURGERY	
OPHTHALMOLOGY	
ORTHOPEDECS	
UROLOGY	
PLASTIC AND RECONSTRUCTIVE	
THORACIC AND VASCULAR	
CARDIAC	
TOTAL NUMBER OF CASES DONE AS OPD	

**ANESTHETIC TECHNIQUE PERFORMED**

GETA	
GA (MASK/SGA)	
TIVA	
MAC/IV SEDATION	
EPIDURAL	
SPINAL	
COMBINED SPINAL AND EPIDURAL	
PERIPHERAL NERVE BLOCK	

**TRAINEE CENSUS 20\_\_\_\_\_**

1. No of RESIDENTS WHO TOOK RITE THIS YEAR	
2. No of RESIDENTS WHO PASSED RITE	
3. No of RESIDENTS WHO TOOK THE WRITTEN <i>BASIC EXAM</i>	
4. No of RESIDENTS WHO PASSED WRITTEN <i>BASIC EXAM</i>	
5. No of GRADUATES WHO TOOK THE WRITTEN <i>CLINICAL EXAM</i>	
6. No of GRADUATES WHO PASSED THE WRITTEN <i>CLINICAL EXAM</i>	
7. No of GRADUATES WHO TOOK THE PBA <i>ORAL EXAM</i>	
8. No of GRADUATES WHO PASSED THE PBA <i>ORAL EXAM</i>	
9. No of GRADUATES WHO TOOK THE PBA <i>PRACTICAL EXAM</i>	
10. No of GRADUATES WHO PASSED THE PBA <i>PRACTICAL EXAM</i>	
11. No of GRADUATES CONFERRED AS DPBA	

**DIDACTIC AND ACADEMIC ACTIVITIES**

1. No. of GRAND ROUNDS	
2. No. of JOURNAL CLUBS	
3. No. of MORBIDITY AND MORTALITY CONFERENCE	
4. No. of CASE MANAGEMENT CONFERENCE	
5. No. of RESIDENT-LED LECTURES	
6. No. of FACULTY-LED LECTURES	
7. No. of CENSUS AND AUDIT SESSION	
8. OTHER EDUCATIONAL ACTIVITIES (PLEASE INDICATE)	
9. No. of SIMULATION ACTIVITIES	
10. No. of COMPLETED RESEARCH	
11. No. of CASE REPORT	
12. No. of SCIENTIFIC PAPERS PRESENTED IN LOCAL/INTERNATIONAL FORUM	
13. ATTENDANCE TO PSA ANNUAL CONVENTION	
No. of CONSULTANTS	
No of RESIDENTS	
14. ATTENDANCE TO PSA MIDYEAR CONVENTION	
No. of CONSULTANTS	
No. of RESIDENTS	
15. ATTENDANCE TO PBA-LED ACTIVITIES	
PBA SUMMIT	

PBA TOWN HALL MEETING	
16. ATTENDANCE TO NON-PSA NON-PBA WORKSHOPS OR COVENTIONS	
No. of CONSULTANTS	
No. of RESIDENTS	

Please attach a list of topics covered in activities 1-6.

Please attach a list of scientific paper output and indicate if presented in local/international fora.

Please attach a list of workshops or conventions associated with no 16, including the activity type, title, date and names of participants.

### PERFORMANCE AND ASSESSMENT

1. No. of QUIZZES (<20 ITEMS) GIVEN	
2. No. of LONG QUIZZES (100 ITEMS WITH 70% HOTS) ADMINISTERED	
3. No. of COMPREHENSIVE EXAM (200 ITEMS) ADMINISTERED	
4. No. of ORAL EXAMINATIONS ADMINISTERED	
5. Average no. of CASE-BASED DISCUSSION PER RESIDENTS	
6. Average no of MINI-CEX PER RESIDENT	
7. Average no. of DOPS PER RESIDENT	
8. OTHER, PLEASE SPECIFY	

1. No. of M AND M CASES REVIEWED (WHETHER PRESENTED OR NOT) <i>Please attach list of key lessons learned to improve patient safety</i>	
2. No. of RESIDENT FEEDBACK ON FACULTY (ANONYMIZED) <i>Please attach summary of resident feedback on faculty</i>	
3. No. of ACTIVITIES CONDUCTED TO ADDRESS RESIDENT BURNOUT OR MENTAL HEALTH <i>Please attach list of activities with documentation</i>	

### QUALITY AND SAFETY

<b>FACILITIES AND RESOURCES</b>	
1. EQUIPMENT UPGRADE	
2. LIBRARY AND DIGITAL ACCESS	
3. OTHERS	
<b>CHALLENGES AND ACTION PLAN</b>	
1. IDENTIFIED GAPS (EX. LOW VOLUME OF PEDIA PATIENTS)	
2. PROPOSED SOLUTIONS	

CERTIFIED TRUE AND CORRECT:

TRAINING OFFICER:

Date:

Signature:

DEPARTMENT CHAIR:

Date:

Signature:

NOTED:

HOSPITAL DIRECTOR:

Date:

Signature: