فقيه.

كلية فقيه للعلوم الطبية

Fakeeh College for Medical Sciences

FAKEEH COLLEGE FOR MEDICAL SCIENCES

MBBS

POLICY AND PROCEDURE MANUAL

AUGUST 2026

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Program Management and Quality Assurance

Fakeeh College for Medical Sciences	Policy Number: PMQA-MBBS-01	
Policy Title: Periodic revision of MBBS Program Mission and By-laws	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	**To be Reviewed on: 15-01-2029**	

Statement of the Purpose	To ensure that the MBBS Program Mission statements and regulations are kept up to date by reviewing it periodically and also in the light of changing circumstances.
Policy	1. This policy is to ensure that periodic review and feedback gathered on its Mission, goals and Program policies and regulations by means of a broad range of input from the stakeholders and independent reviewers to make it up-to-date and to match with the current status. 2. MBBS program staff, students and other stakeholders' awareness on 'Mission" statement is measured on annual basis by conducting a mission awareness survey. 3. The Mission review process is applicable for institutional Mission as well as for all FCMS programs.

Procedure

Procedure steps	Responsibility
Review process: 1. FCMS College Council (CC) with the program management will decide on the Mission review process whenever there are significant changes in the Program's nature or/and at least once in every five years as part of the "Strategic Plan" revision.	**College Council program management**
2. The FCMS Strategic Planning Unit (SPU) in coordination with the Strategic Planning Steering Committee (SPSC) and Strategic Plan Monitoring Committee at the program level is responsible for initiating the review process.	**Strategic Planning Unit (SPU) & Strategic Planning Steering Committee (SPSC)**
3. MBBS staff, students and other stakeholders will be informed about the circumstances of Mission review process and their feedback is gathered through participating and/ or completing a Mission review survey format. (See Annex No-1)	**MBBS stakeholders**
4. The SPU will submit the initial draft of the revised mission statements to Strategic Planning Steering Committee for feedback.	**SPU**

	5. The CC will share the revised draft with the College Board of Trustees (BOT) for review and comment, and the final draft is prepared.	**Board of Trustees (BOT)**
	6. Once approved by BOT, it will be widely published through cards, LCDs, College Website, and other official documents.	**SPU**
	7. A copy of mission card will be distributed to MBBS Program staff and students.	**Strategic Planning Unit**
	8. Stakeholders awareness and agreement on MBBS Program approved mission and objectives is annually measured by a survey (see Annex No-2).	**Quality and Accreditation Unit**
	9. The survey results are taken into consideration for reviewing the mission statements by SPU.	**Strategic Planning Unit**

Fakeeh College for Medical Sciences	Policy Number: PMQA-MBBS-02	
Policy Title: Committee and taskforce team Formation	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 01-01-2024	
Applicable to: FCMS/ MBBS Program	**To be Reviewed on: 31-12-2029**	

Statement of the Purpose	1. To define the steps for establishing and guiding the operation of committees and taskforce teams in the MBBS program. 2. To ensure the efficiency, by avoiding duplication of objectives and/or functions of established committees and taskforce teams. 3. To ensure clear communication and workflow through well planned, organized meetings.
Policy	1. It is the policy of the MBBS program to encourage team work at all levels by involving members from male and female sections and from all Departments/ Units to be represented in program's committees and taskforce teams. 2. The authority to appoint or terminate any member from the program's committees' rests only with the Dean of the College. 3. MBBS program's standing committee membership will be assigned for a period of time during an Academic year. 4. All committees shall hold meetings as per terms of reference. 5. Attendance is mandatory for all the members. 6. All meetings shall be minuted and filed and kept with the Chairperson and copy of minutes to be sent to Dean's Office and QAU.

Procedure

Procedure steps	Responsibility
1. The initiator identifies a need for a committee and submits the request, TOR and attaches any documents that could support the establishment of the committee to the QAU for reviewing and evaluating the TOR.	**Initiator**
2. QAU will review the TOR and ensure that similar committee or taskforce team does not exist then propose it to College's Dean for approval. The Dean will decide the membership to be represented in the committee.	**QAU**
3. The approved and signed terms of references return to the QAU and will keep the original copy and circulate scanned copies of the Committee Formation	**QAU**

	Order Form (Attachment No.5.1) and the TOR to assigned members and update the college committee index accordingly.	
	4. The Committee Chairman calls for the first meeting of the committee within the first two weeks of receiving the Committee Formation Order form.	**Committee chairperson**
	5. The Committee Chairman sends call for meeting, and the minutes via intranet taken after each meeting to committee members and copied to college Dean and QAU.	**Committee chairperson**
	6. Guidelines for committee operation: Responsibilities of committee Chairman	
	6.1 The main responsibility of the Chairman is to ensure that the committee's direction is maintained within its established TOR, commencing from the time of receiving official notification.	**Committee chairperson**
	6.2 Committee Chairman prepares the agenda, sends call for meeting, and minutes via intranet taken after each meeting to committee members and copied to Dean and QAU Director.	**Committee chairperson**
	6.3 Opens, conducts and adjourns meetings.	**Committee chairperson**
	6.4 Organizes, promotes participation of members, and control debate.	**Committee chairperson**
	6.5 Count votes and announces the results.	**Committee chairperson**
	6.6 Authenticates and ensures timely completion of minutes of committee meetings.	**Committee chairperson**
	6.7 Recommends sub-committees upon committee's action. (for standing committees only).	**Committee chairperson**
	6.8 Prepares, reviews, authenticates and submits committee reports and recommendations, as required.	**Committee chairperson**
	6.9 Follows up on the absenteeism of members.	**Committee chairperson**
	6.10 Requests replacement due to a vacancy, or frequent absenteeism, from appointing authority.	**Committee chairperson**

	6.11 Establish policies, annual goals, activity plan and budget needed activities at the beginning of each academic year and submit to Dean's approval.	**Committee chairperson**
	6.12 Ensures that the committee's assigned responsibilities are completed in a proper and timely manner according to the TOR.	**Committee chairperson**
	6.13 Following every meeting the chairman will highlight all issues arising that require referral for action and/or referral for approval from another entity (department, section, individual or committee)	**Committee chairperson**
	6.14 Informs the Dean of any constraints hindering the accomplishment of the assigned duties.	**Committee chairperson**
	6.15 Informs the Dean of the membership update (status) and ensures delegation of membership is based on appropriate approval of the above authority.	**Committee chairperson**
	6.16 Submits an Annual Review Report to Dean and QAU at the end of each academic year.	**Committee chairperson**
	7. Responsibilities of <u>Member of a Committee</u>: is expected to contribute time and effort towards the achievement of the committee functions. Basic duties include the following:	**Committee members**
	7.1 Attends the committee meetings on time and any delay for 10 minutes considered as absenteeism.	**Committee members**
	7.2 Notifies the secretary or chairman and department director of justified absence, within a reasonable time before any scheduled meetings. His/her department director will assign an acting member/representative to attend on his behalf.	**Committee members**
	7.3 Complies with confidentiality requirements of issues, as applicable.	**Committee members**
	7.4 Retires from that portion of the meeting where matters relating to him/her are under debate, or where conflict of interest arises.	**Committee members**
	7.5 Informs immediate supervisor of the frequency of meetings, completion of	**Committee members**

assignment and pertinent information to department operation as necessary.	
7.6 Volunteers and willingly accepts assignments and complete it on time.	**Committee members**
7.7 The secretary of the committee is responsible for taking and typing the minutes and preparing any material for the committee meeting with the coordination of the committee chairman.	**Committee Secretary**
8. Delegation of Membership:	
8.1 All committee members must attend the meetings. A permanent delegation of membership may be accepted only through notifying the committee chairman.	**Committee members**
8.2 The Chairman may temporarily delegate authority to another (voting) member to serve as Acting Chairman during official leaves with the approval of the Dean.	**Committee chairperson**
8.3 During an official leave of a committee member, the member in coordination with his/her organizational unit may recommend the appointment of another person to act on behalf of the absent member.	**Committee members**
8.4 When a member will not be able to attend a committee meeting due to unavoidable circumstances, a temporary replacement shall be arranged with the committee chairman through his/her Department Director ahead of the meeting time.	**Committee members**
9. **Absenteeism:** Members who are absent for no valid reason for three or more consecutive meetings may be reported to the Dean and replacement requested.	**Committee chairperson**
10. **Meetings:** Meetings should be conducted in a timely, professional, and orderly manner, taking into consideration the requirements set below.	**Committee chairperson**
10.1 Meetings will not become official unless called to order by the Committee Chairman or his/her representative.	**Committee chairperson**
10.2 Frequency of the meetings will be determined based on the volume of its activities. (If not as specified in the TOR)	**Committee chairperson**

	11. Agenda: The agenda is prepared by the Chairman.	
	11.1 The agenda should be according to the committee's functions and activities as stated in the committee's terms of reference.	**Committee chairperson**
	11.2 Unfinished business should be included in the agenda of the next meeting as old business for further discussion prior to new business.	**Committee chairperson**
	11.3 The urgent or important items should come before those of less importance.	**Committee chairperson**
	11.4 It should include the time the meeting will start, time allocated for each item and adjournment.	**Committee chairperson**
	11.5 The members should adhere to the agenda. To take up any item of business out of its proper order or re-scheduled requires a two-thirds vote.	**Committee members**
	12. Minutes: are the vital importance to the record keeping of committee as they reflect the official activities of the committee and provide reference to the organization:	
	12.1 The secretary should prepare the minutes as soon as possible after a meeting.	**Committee secretary**
	12.2 Minutes of the previous meeting should be distributed to members prior to the next meeting, and should be presented as the first item on the agenda.	**Committee secretary**
	12.3 The minutes are certified by the signature and approval of the Chairman.	**Committee Secretary**
	12.4 A hard copy of the official approved minutes for all committees will be sent to QAU and scanned copy will be sent through intranet to the members.	**Committee secretary**
	12.5 Minutes of a meeting must include the following:	**Committee secretary**
	a. Name of the committee. b. Date, hour, place meeting was called to order. c. Name of the chairman and the present members (acting/representative) and the fact that a quorum was present.	

	d. Name of absent members (on leave, excused, emergency, or un-excused absence and vacation). e. Status of items on the agenda (open and closed). f. Summary of any reports presented or debated. g. All main suggestions, excluding those withdrawn. h. Voting (yes, no and abstentions).	
	12.6 In the absence of a quorum, the Chairman calls the meeting to order, announces the absence of a quorum, and entertains a motion to adjourn or recess, or takes measures to obtain a quorum.	**Committee chairperson**
	12.7 **Debate**: In order to reach an appropriate decision on proposals submitted to a committee, exchange of ideas through debate is encouraged. Debate must be fundamentally impersonal. Discussion must be relevant to the subject.	**Committee members**
	12.7.1 The Chairman opens the agenda items for discussion/debate in an orderly manner giving enough opportunity for members to speak. Reasonable time should be given by the Chairman for the discussion or debate of each item.	**Committee chairperson**
	12.7.2 No member can make a motion or address the meeting unless permission is granted by the Chairman.	**Committee chairperson**
	12.7.3 All discussions should be addressed to/through the Chairman and must never be directed to any individual.	**Committee chairperson**
	12.7.4 Members should not interrupt the speakers and/or disturb the meeting. Side conversation between members is considered an out of order conduct.	**Committee chairperson**
	12.7.5 The Chairman has the responsibility of controlling and expediting debate.	**Committee chairperson**
	12.7.6 When the debate appears to the Chairman to be finished, he should initiate the closing of the debate.	**Committee chairperson**

	13. **Voting:** Members should vote freely without concern for undue course. Voting can be affirmative, negative or by abstention	**Committee members**
	13.1 If the question is undebatable or debate has been closed by order of the committee, the Chairman may put it to a vote, first calling for the affirmative and then for the negative vote and abstentions.	**Committee members**
	13.2 The vote should be taken by "show of hands", however, other methods of voting may be adapted by 2/3 vote.	**Committee members**
	13.3 The responsibility of announcing or declaring the vote results with the Chairman. If there is doubt as to the result, the votes should be recounted.	**Committee chairperson**
	13.4 The Chairman has the same voting right as any other committee member.	**Committee chairperson**
	13.5 A member has the right to change a vote up to the time the vote is finally announced.	**Committee members**
	14. **Points of Order:** it is the duty of the Chairman to enforce the rules and the orders of the committee without debate or delay.	**Committee chairperson**
	14.1 Every member who notices the breach of a rule has the right to raise a point of order.	**Committee members**
	14.2 A point of order must be raised at the time the breach of order occurs.	**Committee members**
	14.3 The Chairman decides the validity of the point of order; however, an appeal may be made immediately at the time of the ruling.	**Committee chairperson**
	15. **Adjournment:** Time of adjournment is normally fixed on the agenda; however, adjournment may take place before or after such time.	**Committee chairperson**
	15.1 The announcement of adjourning a meeting is the responsibility of the Chairman as the presiding officer	**Committee chairperson**
	15.2 Members should not leave their seats until the Chairman has declared the meeting adjourned.	**Committee members**

	16. **Committee Annual Review Reports:** A committee report should be as brief, clear and accurate and include the following:	**Committee chairperson & members**
	16.1 A brief explanation of the methodology or how the committee carried out its work and the number of man-hours consumed to accomplish its tasks. 16.2 A description of the work that the committee performed, its findings and conclusions. (Investigation committee) 16.3 Committee reports should be printed in advance and distributed to members prior to the meeting. 16.4 The committee report should be presented to the committee by its Chairman or by a representative member of the committee. 16.5 Committee report after being presented to the committee should be open for comment, questions and discussion. 16.6 The Chairman must sign the final form of the report, after being approved by the committee. 16.7 All standing committees and Sub-committees will submit annual reports to the College Dean and copied to QAU. 16.8 The report, after being submitted to the Dean, may be referred to the committee for further study, modification or recommendation.	**Committee chairperson & members**
	17. Dissolution of a Committee: Only the appointing authority (College Dean) can dissolve the committee any time during its operation.	**College Dean**
	17.1 Unless otherwise specified, Sub-Committee, Ad hoc (Task Force) will be dissolved automatically upon acceptance, by the appointing authority of their final report.	**College Dean**
	17.2 The appointing authority, upon receipt of the committee report, should decide on the merit of performance and status of the committee within one-month period; otherwise, the committee is considered dissolved.	**College Dean**

	17.3A Standing Committee may recommend its dissolution for certain reasons, by a unanimous vote of its members. Such recommendations should be documented.	

Fakeeh College for Medical Sciences	Policy Number: PMQA-MBBS-03	
Policy Title: Committee self-evaluation	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	To maintain and improve services provided by the MBBS program's committees, and to improve the satisfaction over the quality of services provided by the committees.
Policy	1. MBBS program's leadership believes that self-evaluation of its committees is an important measure to identify the strengths and weaknesses, therefore, to improve the quality of performance.

Procedure

Procedure steps	Responsibility
1. Self-evaluation process is conducted annually by all MBBS program Committees' members including Departmental Council.	**Committee members**
2. Committee chairpersons will evaluate the performance based on the evaluations of committee members and will present the report in the Committee.	**Committee chairperson**
3. Based on the self-evaluation report committee will adopt new strategies for enhancing committee performance if required.	**Committee chairpersons**
4. The self-evaluation reports of the MBBS program's Committees will be submitted to the QAU.	**Committee chairperson:**
5. The QAU will prepare a comprehensive report on committee's activities annually and submit to the college Dean and Quality and Accreditation Steering Committee for review and approval.	**QAU**

Fakeeh College for Medical Sciences	Policy Number: PMQA-MBBS-04	
Policy Title: Benchmarking Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 7-1-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 7-1-2029	

Statement of the Purpose	To establish guidelines for comparison of MBBS program achievement with internal and external alike programs.
Policy	1. The MBBS program aims to enhance its performance by benchmarking against established standards and comparable institutions to adopt best practices and ensure continuous improvement. 2. Benchmarking partners are selected by the Quality and Accreditation Steering Committee (QASC) based on the following criteria: • Comparable mission, vision, values, and goals • Similar program structure, discipline mix, and size • Nationally or internationally accredited with a strong reputation • Availability and willingness to share performance data • Accessibility and feasibility of collaboration • Cultural and institutional compatibility 3. Formal agreements should be established with FCMS and external organizations to facilitate benchmarking collaborations.

Procedure

Procedure Steps	Responsibility
1. Planning Phase:	
1.1 Identify the key benchmarking focus areas that align with the program's goals.	**MBBS Program Steering Committee (MPSC) Program Quality Assurance Committee (P-QAC)**
1.2 Select benchmarking partners (internal and external) based on the approved criteria.	**QASC**
1.3 Establish benchmarking focus areas and KPIs/Performance Indicators (PIs), then seek approval from the Quality and Accreditation Steering Committee (QASC).	**P-QAC MPSC**
2. Implementation Phase (Data Collection and Analysis)	

2.1 Prepare and validate information and data at the program level.	**P-QAC** **Quality and Accreditation Unit (QAU)**
2.2 Share verified information and data with benchmarking partners (internal and external).	**Vice Dean for Development and Quality Management (VDDQM)**
2.3 Communicate and gather benchmarking information from external organizations.	**VDDQM**
2.4 Conduct a comparative analysis to: • Identify performance gaps • Highlight best practices • Determine achievable targets	**P-QAC** **QAU**
2.5 Develop a benchmarking report including: • Comparative results • Gap analysis • Recommendations • Proposed action plan for improvement	**P-QAC** **QAU**
3. Review Phase (Evaluation and Approval)	
3.1 Review benchmarking report and findings and recommend action plans for improvement.	**MPSC** **QASC**
3.2 Evaluate whether benchmarking objectives and targets have been achieved.	**MPSC** **QASC**
3.3 Verify the identified gaps and improvement priorities.	**MPSC** **QASC**
3.4 Approve the benchmarking report.	**QASC**
4. Improvement Phase (Action and Continuous Enhancement)	
4.1 Implement approved action plans and improvement strategies.	**P-QAC** **MPSC**
4.2 Monitor progress through KPIs and periodic reports.	**QAU** **QASC**
4.3 Update processes, KPIs, and benchmarking practices for continuous improvement.	**QASC**
4.4 Conduct the benchmarking cycle yearly to ensure quality assurance and continuous improvement.	**QASC**

Fakeeh College for Medical Sciences	Policy Number: PMQA-MBBS-05	
Policy Title: Internal Quality Assurance System (IQAS) Monitoring	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	1. To ensure that the program achieves and maintains its quality standards and progress towards advancements. 2. To establish a structured framework for the MBBS program to ensure continuous quality improvement (CQI). 3. To monitor, evaluate, and enhance academic and administrative performance. 4. To ensure compliance with accreditation standards and support full program accreditation. 5. To identify strengths and areas requiring improvement and promote excellence.
Policy	1. MBBS administration always aims to verify its achievement on quality standards and improve its performance to achieve excellence. 2. Time Specification: Quality and Accreditation Steering Committee (QASC) formulates the IQAS review team to initiate monitoring process from September to August every Academic year. The IQAS team reporting schedule is as follows: • 1st Report to be submitted to QASC by December • 2nd Report to be submitted to QASC by March • Final Report to be submitted to QASC by August 3. The scope of assessment includes: teaching and learning process, curriculum, academic administration, student guidance, assessment process, teaching and learning environment, adequacy of resources and facilities and other NCAAA quality standards.
Procedure	

Procedure steps	Responsibility
1. QASC formulates an IQAS review team for each academic year.	**QASC**
2. The IQAS review team evaluates the activities and performances (based on the IQAS evaluation guide: see the attachment-1) using the IQAS monitoring tool (see the attachment-3).	**IQAS Review team**
3. The IQAS team submits a progress report including findings and preliminary recommendations.	**IQAS Review team**

	4. The IQAS review team regularly monitors the quality of performance and report to QASC as per agreed timeline	**IQAS Review team**
	5. The IQAS team develops recommendations and action plans.	**IQAS Review team**
	6. The recommendations will be discussed in QASC and measures will be taken accordingly.	**QASC**
	7. The IQAS team monitors implementation of action plans with stakeholders.	**IQAS Review team**
	8. The chairperson of IQAS team prepares and submits the final report.	**Chairperson of IQAS Review Team**
	9. QASC Committee review and approve IQAS reports	**QASC**

Fakeeh College for Medical Sciences	Policy Number: PMQA-MBBS-06	
Policy Title: Key Performance Indicator selection monitoring and reporting	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	**To be Reviewed on: 15-01-2029**	

Statement of the Purpose	To guide the selection, monitoring and reporting of Key Performance Indicators (KPIs) at the MBBS program.
Policy	1. KPIs selection and development is done mainly according to the guidelines by National Commission for Academic Assessment and Accreditation (NCAAA). 2. Additional indicators can be selected by program in consultation with Quality and Accreditation Unit (QAU) with final approval from Quality and accreditation steering committee (QASC). 3. Regular monitoring and reporting on program KPIs are the responsibilities of the MBBS program director. 4. If any KPIs data reflects negative trend or variances this has to be analyzed critically and initiate performance improvement plans by the MBBS program and QAU.

Procedure

Procedure steps	Responsibility
1. Identify the KPIs that measure the achievements of MBBS Program	**MBBS Program director Program Quality Assurance Committee (P-QAC)**
2. Complete the required information on the KPI card and submit it to QAU (see Annex-1).	**MBBS Program director P-QAC**
3. QAU will verify the requested KPIs and submit it to QASC for final approval.	**QAU**
4. MBBS Program will collect data on KPIs as per collection schedule (annually or bi-annually) and submit it to QAU.	**MBBS Program director**
5. Analyze the collected KPIs data and prepare the statistical reports	**MBBS Program director**
6. KPI results compared to internal, external and targets benchmarks.	**MBBS Program director P-QAC**
7. Submit the KPI reports to QAU according to the KPI monitoring schedule.	**MBBS Program director**

8.	QAU will present KPI report at program level and present the statistical report on all program indicators in QASC with action recommendations (if applicable).	**QAU**
9.	MBBS program director is responsible for developing action plans to improve the status based on the report.	**MBBS Program director**
10.	Develop improvement action plans with clear timelines, and responsibilities.	**MBBS Program director**
11.	Implement and monitor action plans and track progress against targets.	**MBBS Program director**
12.	Evaluate effectiveness of implemented actions in subsequent KPI cycles (closing the CQI loop).	**QASC**
13.	Publish and disseminate final KPI reports at college level ensuring transparency and stakeholder awareness.	**Vice Dean for Development and Quality Management**

Fakeeh College for Medical Sciences	Policy Number: PMQA-MBBS-07	
Policy Title: MBBS Budget Preparation Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 9-1-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 9-1-2025	

Statement of the Purpose	1. To ensure a sound financial platform for the continued operation of the Bachelor of Medicine, Bachelor of Surgery (MBBS) program at Fakeeh College for Medical Sciences (FCMS). 2. To ensure appropriate equitable allocation and distribution of available financial resources to the program based on the college and program mission, goals and strategic priorities. 3. To establish direct link between the MBBS program planning and financial processes.
Policy	1. Board of Trustees (BOT) requires FCMS administration to prepare, publish and operate the FCMS' programs' based on agreed upon and approved annual budget. 2. The Director of Administration and Finance (DAF) in conjunction with the Dean and program directors are responsible for preparing, agreeing, operating and reporting against the approved annual budgets. 3. Annual budgets are prepared with the input from all organizational Units. 4. MBBS program director (PD) assists in the preparation by projecting his/her program needs to help in meeting organizational goals and will operate his/her program according to the approved annual budgets. 5. MBBS PD will be responsible for the program performance and compliance to the approved FCMS annual budget. 6. Finance Unit (FU) Manager will formally monitor the compliance with the approved annual budget. 7. Aggregated and correlated budget data are considered confidential and will have limited access. 8. The preparation and reporting of the annual Budget will comply with the guidelines as directed herein.

Procedure		
	Procedure Steps	**Responsibility**
	1. **Distribution of Budget Preparation Forms:** The DAF will circulate the forms to all organizational Units including PDs and Head of Departments (HOD) through the Dean during the last week of August every year.	**DAF**
	2. **Budget Preparation Forms Completion and Submission:** PD and HOD will complete the budget preparation forms and will return them to the DAF by the second week of October.	**MBBS PD**
	3. **Meeting with Budget Preparation Taskforce:** The DAF will schedule necessary meetings with the MBBS PD to discuss the submitted forms. This stage will be completed by middle of November.	**DAF**
	4. **Annual Budget Preparation:** The FU Manager will prepare the FCMS's and MBBS Program Annual Budget proposal in conjunction with the DAF encompassing the inputs from the organizational Units. This stage will be completed by the end of November.	**FU Manager**
	5. **Budget Submission:** DAF will discuss the budget proposal in the Financial Review and Monitoring Committee (FRMC) and submit it to the College Council (CC) for ratification by the first week of December The Dean will submit the budget proposal to the Chairman, BOT for approval by the second week of December	**DAF** **Dean**
	6. **Budget Approval:** Upon Approval of the budget from the Chairman, Board of Trustees, the same will be formalized as an approved budget for the approved fiscal year.	**Chairman, Board of Trustees**
	7. **Quarterly Reporting:** The Dean will present quarterly reports to the Chairman, Board of Trustees on budget variance.	**Dean**
	8. **Review of Significant Changes:** If significant changes occur in the operative or budget assumptions, the FU Manager in conjunction with the DAF will review such changes**.**	**DAF**
	9. **Financial Carry-Forward Provisions:**	**DAF**

	Financial carry-forward provisions are the responsibility of the DAF to avoid rushed end of year expenditure or disincentives for long term planning.	
10.	**Submission of Budget Amendments** Any changes to the budget will be submitted to Chairman, Board of Trustees for approval.	**Chairman, Board of Trustees**

Fakeeh College for Medical Sciences	Policy Number: PMQA-MBBS-08	
Policy Title: MBBS Manpower Plan Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	To define standard structure for yearly Bachelor of Medicine, Bachelor of Surgery (MBBS) program manpower planning, to establish framework that will ensure sufficient levels of competent staff in the department to fulfill the requirements of Fakeeh College for Medical Sciences (FCMS).
Policy	1. FCMS reviews the MBBS program Manpower Plan on an annual basis. 2. FCMS holds Direct Reports fully accountable for identifying and presenting manpower needs. 3. The Board of Trustees (BOT) holds the ultimate authority for approval of the college Manpower Plan including the MBBS program. 4. FCMS maintains a Job Position and Grading Catalogue with hyperlinked Job Descriptions which includes every approved MBBS program job title. 5. The Dean holds the sole approval authority for adding positions to the MBBS program manpower. No positions will be added without the written approval of the Dean. Deletions can be approved by the College Operational Committee (COC). 6. The Director of Administration and Finance (DAF) reserves the right to ask for justification from MBBS Program Director requesting addition of a position that does not correspond to approve organizational definitions. The approval of the Dean is required for any position that does not meet the approved definition.
Procedure	

Procedure steps	Responsibility
1. The DAF will circulate the manpower form to all organizational Units including MBBS Program Director through the Dean on the last week of August every year.	**DAF**
2. The Program Director will complete the form and return it to DAF by the second week of October.	**The Program Director**
3. HRU Manager is responsible for all coordination Manpower review activities.	**HRU Manager**
4. DAF will arrange a mutual arrangement acceptable meeting times with direct reports to discuss the workforce needs for the coming year.	**DAF**

	5. Hierarchal Position Title framework is followed during the manpower review process.	**The HRU Manager**
	6. The HRU Manager compiles the requirements in the annual workforce plan and obtains the approval of the lists of the relevant direct report and Dean.	**The HRU Manager**
	7. Program Director should consider the following while planning next year staff. • Mission and Vision • The new curriculum planned to implement. • The students number. • Changes in technology in teaching. • New majors at FCMS • Budget. • Changes in Organization. • Turnover rate of previous year.	**Program Director**
	8. A workforce review is conducted annually in December.	**DAF**
	9. DAF discusses in the COC before finalizing the actual plan.	**DAF**
	10. After all meeting final report is sent to Dean for approval.	**DAF**
	11. Manpower Plans presented to Chairman of BOT for the final approval.	**Dean**
	12. Manpower plans will be also revised to reflect any changes in organizational structure.	**DAF** **Dean**

Teaching and Learning

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-01	
Policy Title: Curriculum Review Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	To provide guidelines for modifying or changing MBBS Program courses/curriculum to meet the health care challenging needs of Saudi society. Curriculum review aims at supporting ongoing quality and improvement of academic processes, and outcomes through reviewing the change in methods of delivery of the curriculum, and course specifications.
Policy	1. MBBS program is due for a curriculum review every 5-7 years (after the graduation of at least one batch) to determine the effectiveness of the current curriculum and make decisions about the future. 2. Review process of the curriculum should reflect rigor, integrity, objectivity, teamwork and accountability. 3. Major review process of the curriculum should include: • A clear statement of the scope for the review. • Clearly defined responsibility and terms of reference for all stages of the review. • Reference to stakeholders' feedback. • Reference to similar program key performance indicators. • Communication and implementation of the outcome of the review. • Appropriate documentation of all stages of the review. • Reviewing Graduate attributes, Program Learning Outcomes, Courses delivered, Teaching Strategies and Assessment Methods etc. • Minor review process is justified and documented.
Procedure	

Procedure Steps	Responsibilities
1. **Minor Curriculum Changes/Modifications:**	
1.1 These are first requested at MBBS Program Steering Committee (MPSC) (e.g. proposed by a course instructor for his/her course specification or written as action plan in an instructor's action	**Stakeholders**

	plan in the course report or recommended by one of Stakeholders). In addition, these changes could be requested at higher level e. g., by a reviewing committee or by experts.	
	1.2 These proposed Curriculum changes in addition to their justification/rational are discussed by the MPSC who will submit their approved recommendations to the Curriculum Development and Monitoring Unit.	**MPSC**
	1.3 The approved recommendations are submitted to CDMU as a part of the Department of Medical Education (MED) for further review (with a copy to VDQDM) and then CDMU submits the reviewed and approved recommendations to the Institutional Curriculum Review and Monitoring Committee (ICRMC) for further action then to the College Council (CC) for final decision.	**CDMU** **ICRMC** **CC**
	2. **Major curriculum changes:**	
	2.1 The changes follow the same process of minor changes until they are approved from MPSC then to be submitted to internal and external reviewer assigned through MPSC. The reviewers revise the program according to specific checklist. All the reviewers' comments are discussed and addressed in MPSC. The reviewed approved program specification is submitted to the ICRMC. Then to the College Council which may either: 2.1.1. Approve the recommendations to be submitted to the Board of Trustees for review (BOT) for final approval. Or 2.1.2. Disapprove the changes to return back to the MED and then to the concerned Head of Department/ Director of Program for further review.	**MPSC** **ICRMC** **CC**
	2.2 The Board of Trustees (BOT) either: 2.2.1. Approve the recommendations to be submitted to MOE for final approval. Or	**BOT**

	2.2.2. Disapproves recommendations to be submitted back to the Dean and then to MED and then to the concerned Head of Department/Director of Program for further review.	
	3. **Implementation of approved changes:**	
	3.1. For minor changes, implementation of the approved curriculum is applied once approved by The College Council.	**CC** **MED** **HOD**
	3.2. For major changes implementation of the curriculum is started at the beginning of the new academic year after obtaining the final approval of MOE.	**Dean** **MED** **HOD**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-02	
Policy Title: Student Academic Advising and monitoring Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version Approved on: 15-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	1. Guide students during their academic study in MBBS program and facilitate their learning process in order to become self-directed learners and decision makers. 2. Help students' intellectual discovery and encourage them to take advantage of educational opportunities provided in teaching sessions and during clinical training as well as encourage extracurricular activities.
Policy	1. All students in MBBS program will have an assigned academic advisor to follow their progress throughout the study period and guide them in achieving their goals. 2. The Academic Advising (AA) process is coordinated by the Student Academic Advising and Support Unit (SAASU). The unit is under the direct supervision of the Vice Dean of the Academic Affairs (VDAA).

Procedure

Procedure Steps	Responsibility
1. Planning stage:	
1.1 Conduct orientation and awareness session for MBBS Program students (advisees) about the academic advising.	**SAASU**
1.2 Conduct orientation and awareness session for faculty staff members (advisors) about the academic advising process and their roles and responsibilities.	**SAASU**
1.3 Develop academic advisor guide that includes clear roles and responsibilities for advisees and advisors	**SAASU**
1.4 The SAASU assigns an academic advisor for each student and organizes an initial meeting during the orientation program through the VDAA.	**SAASU**
2. Implementation stage:	

	2.1 The SAASU organizes mandatory meetings between academic advisors and their assigned students as follows:	**SAASU**
	2.2 Conduct the first meeting during the first week of the academic year and discuss the following: • Explain the goals of the AA process and discuss how confidentiality should be maintained. • Talk informally about non-academic matters to keep the advisee relaxed. • Review the student's current experience and qualifications. • Ask the student to self-assess about his or her strengths and area for improvement. • Ask the student to discuss any concerns they might wish to disclose. • Discuss the student's immediate and long-term goals. • Arrange a meeting schedule. • Fill in the student's health and social status follow-up in the 1st week of each semester. The forms should be submitted to SAASU to make a database for student who need various support like psychological support, financial support etc. Also, student who has various talents, different hobbies are identified and provide support and guidance accordingly. Based on this information the SAASU will create a plan for each student.	**Academic Advisors and Advisees**
	2.3 Conduct group meeting on the 5th week of each semester	**Academic Advisors and Advisees**
	2.4 Additional individual meetings can be organized between the academic advisor and the assigned advisee as needed and this should be documented.	**Academic Advisors and Advisees**
	2.5 Academic advisors follow up their advisees with academic or learning difficulties to identify reasons of poor performance and take	**Academic Advisors**

	appropriate action for improvement accordingly.	
	2.6 Academic advisors refer their advisees with poor academic performance to the Student Support Section (SSS) as part of SAASU to receive appropriate support e.g. arranging extra tutorial sessions for students who have difficulties in understanding the course materials.	**Academic Advisors and SAASU**
	2.7 If the advisee faces specific problems that affect his/her academic performance such as chronic illness, psychological problems or financial hardship, the academic advisor refers the student to the SSS to help students based on his/her needs (financial, social, health, academic support etc...).	**Academic Advisors and SAASU**
	2.8 The academic advisor follows closely with the SSS the progress of poor academic performance students. This will be reported regularly to the Student Progress and Promotion Committee (SPC).	**Academic Advisors and SAASU**
	2.9 MBBS Program director monitors the implementation of the academic advising process, the progress of poor academic performance students and the support given to students.	**MBBS Program director**
	2.10 An action plan is created for students, and progress is discussed on monthly basis in the MBBS Program Steering Committee [MPSC].	**MPSC**
	3. **Evaluation phase**	
	3.1 Student satisfaction survey on the academic advising process is conducted at the end of the academic year by the Quality and Accreditation Unit (QAU).	**QAU**
	3.2 Faculty staff members' satisfaction about the academic advising process is conducted at the end of the academic year by the QAU.	**QAU**
	3.3 The SAASU submits annual report to the Dean.	**SAASU**
	3.4 Internal Quality Assurance System (IQAS) monitors the compliance of this policy and procedures.	**IQAS**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-04	
Policy Title: Peer Review Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	1. Monitor the quality of MBBS staff performance in teaching. 2. Professionally support MBBS staff in particularly in their duties with respect to teaching.
Policy	1. This policy and its associated procedures apply to MBBS teaching staff involved in teaching in the program. 2. Students' achievement is a substantial measuring tool of effective teaching. 3. The peer review aims to improve the MBBS Program faculty performance and maintain the standards of teaching and learning at MBBS Program. 4. This is applicable for the theory courses as well as lab and clinical courses. 5. Following the peer observation, the faculty will be given a feedback focusing on the teaching behaviors and practices. This will include the faculty's strengths, weaknesses and areas of improvement.

Procedure

Procedure Steps	Responsibility
1. **Classroom visits by Peer Reviewers:**	
1.1. Peer review visits provide information about the process of MED teaching. They are arranged by at least two observers (e.g. Medical educationists –peers- Program Director- Heads of departments) and more than one visit is preferred.	**MED**
1.2. The peer reviewers need to plan a schedule for visiting classes and evaluating the faculty.	**MED**
1.3. Peer observation forms which includes special criteria will be used.	**Peer Reviewers**
1.4. Regular class visits are conducted to monitor the process all through the academic year.	**MED**
1.5. The teaching staff is informed regarding the peer review class visit at least 1 hour before his /her teaching session.	**MED**

1.6. The Peer reviewers should stay more than 50% of class time to objectively evaluate quality of teaching and student interaction.	**Peer reviewers**
1.7. Extra visits are conducted to investigate and follow up staff teaching performance when further information is required.	**MED**
2. Evaluation of staff performance after the peer review visit:	
2.1. The information gathered from peer reviewers will be used in the evaluation.	**Peer Reviewers**
2.2. Performance Rating Key categorized as follow:	**Peer Reviewers**

Performance Rating Key				
1	2	3	4	5
Needs Improvement	Satisfactory	Good	Very Good	Excellent
Performance and/ or behavior falls short of the required standard	Performance in most areas met the requirements of the position.	Overall demonstration of consistent and sustained performance with all objectives being met.	Overall demonstration of consistent and sustained performance with all objectives being met and many being exceeded.	Demonstration of performance exceeding expectations.

2.3. Based on the above categorization, poor performers (below 3) are identified.	**Peer Reviewers**
2.4. For those identified as poor performers the followings are conducted*: 2.4.1. Interviews with their students. 2.4.2. Coaching sessions and one to one counseling. 2.4.3. Further follow up visits to monitor their teaching performance.	**Peer Reviewers**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-05	
Policy Title: New Program Approval Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	To provide guidelines for designing and approving new academic programs. It also highlights the process of approving adapted programs from national and international academic institutions.
Policy	1. A new program is proposed based on the current strategic plan of the College and the need for achieving the College Mission for its academic expansion, and in accordance with the needs of the healthcare workforce, considering local, regional, and national demands of the Saudi labor market. 2. The program must adhere to the NCAAA standards ensuring that the curriculum meets rigorous academic and professional criteria. 3. The program should be built upon a clear curricular framework that outlines learning outcomes, course sequences, and assessment methods. 4. The program should encourage integration across various disciplines, fostering a comprehensive approach and understanding of the specialty. 5. The curriculum should emphasize competencies that align with professional standards and accreditation requirements, preparing students for licensure and employment. 6. The faculty staff members involved in the program preparation should possess relevant qualifications, and professional experience. 7. The program is designed in accordance with Kern's Six-Step Approach to Curriculum Development, providing a structured framework for curriculum design, implementation, and continuous evaluation. 8. The proposed program should include the following criteria: 8.1 The program's name and degree designation reflect the program content and purpose. 8.2 The proposed program is congruent with the Vision, Mission, and Strategic Goals of FCMS. 8.3 The admission requirements and preparation needed are appropriate for the Program Learning Outcomes (PLOs). 8.4 The program structure, curriculum, teaching/learning strategies, and assessment methods are consistent with the Program Learning Outcomes (PLOs). 8.5 The resources (physical, human and financial) are available to support the implementation of the proposed program.

	8.6 The proposed program meets the health care needs of Saudi society. 8.7 New programs enable FCMS to stay current in the educational marketplace. 8.8 The new program proposals should be submitted and approved by the College Council (CC) at least six months prior to the start of the first term of the program.
Procedure	

Procedure steps	Responsibilities
1. **Design and Approval process of a newly proposed program:** 1.1. The initiative for a new program may come from students, faculty members, academic departments, college council, and the board of trustees or an external agency.	**Stakeholders**
1.2. The academic department in the College initiates the desire to develop and design a new academic program. A core working group within the department prepares a general outline of the new academic program based on their experience and benchmarking with national and international similar programs in other Universities.	**Academic Department**
1.3. The academic department reviews the prepared outline covering the following: 1.3.1. Name of the program and its code 1.3.2. Vision, mission, aim of the program and goals. 1.3.3. National and international benchmarking with similar programs in other Universities. 1.3.4. Summarized "Study Plan" covering duration of the program, number of credit hours, and required and elective courses.	**Academic Department**

	1.3.5. Listing teaching and learning strategies. 1.3.6. Outlines of assessment plan. 1.3.7. Suggested admission criteria to the program. 1.3.8. Suggested possible career pathway and opportunities. 1.3.9. Suggested governance structure for the program.	
	1.4. The College Dean assigns a "Task Force Team" with clear responsibility to develop the program specification and course specifications according to NCAAA guidelines and templates considering the Key Learning Outcomes (KLOs) in collaboration with the Medical Education Department (MED).	**Dean**
	1.5. The required document should fulfill the requirement of National Qualification Framework (NQF), KLOs and Saudi Standard Classification of Educational Levels and Specializations according to the checklist including the following: 1.5.1. **National Qualification Framework (NQF):** **A. Qualification details** including institution, college, program qualification, qualification name, Area of specialization, qualification types and qualification by domains and major track. **B. Early exit points for educational and training program (if available)** including intermediate exit point,	**Academic Department and MED**

		description of early exit point of the program, level of awarded qualification and qualification awarded at exit point. **C. General Requirement for qualification placement: Including**: Official approval, stakeholders engagement, qualification objectives, qualification title, qualification components (minimum credit hours, program duration and minimum actual contact hours and enrollment conditions), LOs assessment including (LOs alignment with NQF level descriptors and LOs assessment). 1.5.2. **Saudi Standard Classification of Educational Levels and Disciplines:** 1. Minimum requirement for entry into level. 2. The cumulative study period for the level. 3. Credit hours or their equivalent. 4. Duration of the program. 5. The official age of entry into the level. 6. Program orientation. 7. Completion of the level and access to higher levels. 8. Level ranking in the structure of national qualifications. 1.5.3. **Key learning outcomes including:**	

	1. Alignment between new PLOs and KLOs. 2. Essential Knowledge Units (EKU) in the new program at FCMS in alignment with KLOs. 3. Program core Knowledge Units for the academic program in alignment with KLOs.	
	1.6. The new program proposal includes the detailed description of the rationale for the new program with the program and course specifications should be submitted by the department to the Curriculum Development and Monitoring Unit (CDMU).	**Program Director/Head of Department/Task Force Team**
	1.7. The MED feedback and recommendations should be revised by Institutional Curriculum Review and Monitoring Committee (CRMC).	**MED**
	1.8. The Institutional CRMC selects at least two external international reviewers, to review the new academic program proposal and related documents.	**Institutional CRMC**
	1.9. Comments and recommendations of external reviewers shall be taken into consideration. The MED and the Academic Department are responsible to make sure that these comments and recommendations are taken into account within the proposal.	**MED**
	1.10. The MED submits the finalized new program proposal and related documents to institutional CRMC after modification based on the external international reviewers' recommendations.	**MED**

	1.11. Institutional CRMC recommendations to submit the final version of the Program to College Council (CC).	**Institutional CRMC**
	1.12. The CC discusses the new program proposal, approves the program, and submits the recommendations to the Board of Trustees (BOT). If the new program is accepted, the BOT submits the following requirements to CUAs: 1. Complete review of the program specification, and courses specification by a National University using the form. 2. A detailed feasibility study on the approved program as part of the pre-request via an external consultancy. 3. Submission of the program specification, courses specification, feasibility study, and other information required by the SCFHS on its website; to complete the SCFHS review documents in a special form. 4. Once the review from the SCFHS is completed, then all appropriate documents are uploaded officially counting the following documents. a. A covering letter to the Secretary General of CUAs regarding the new academic program. b. Program specification with review from the National University (form). c. The approval of the SCFHS as per form. d. The feasibility study for the program. e. The approval of the BOT.	**CC** **BOT/Dean**

1.13. Once the CUAs approved the program, no further modifications, the College Council sends the program to the MED.	**CC/Dean**
1.14. The MED will send the new program to the concerned department for implementation following ratification by the Dean.	**MED/Dean**
2. **The process of adapting an approved program:**	
2.1. The approved program to be reviewed by the MBBS director and submitted to the MED.	**MBBS director**
2.2. MED will submit the recommendations to the institutional CRMC.	**MED**
2.3. ICRMC will review the recommendations and forward this to the CC.	**ICRMC**
2.4. The CC will forward the program to BOT for review and feedback.	**CC**
2.5. If approved, the BOT will submit the program for MOE approval.	**BOT**
2.6. The BOT will submit the recommendations to MOE for approval.	**BOT**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-06	
Policy Title: MBBS laboratory Utilization Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	This policy provides an approach on the process for the proper use of learning resources inside FCMS laboratories to assist the MBBS Program learning process while maintain the effectiveness of laboratory supplies for optimal practical/clinical practices as well as ensuring long-term utilization.
Policy	1. Faculty staff/students must be fully aware of the laboratory utilization guidelines; this should be a part of their MBBS program orientation as well as the semi-annual safety course orientation. 2. Each laboratory is assigned to a specific laboratory supervisor to monitor the overall operational; activities of the lab, equipment maintenance, equipment acquisition, lab booking, lab inventory and reporting any incident or malfunction inside the laboratories. 3. A unified laboratory schedule will be sent to all MBBS Program course coordinators and laboratory instructors at the beginning of each semester.
Procedure	

Procedure Steps	Responsibility
1. Course Instructors, Module Coordinators, Teaching Assistants and Laboratory supervisors using the lab must fill the lab utilization form before leaving the lab.	**Teaching staff**
2. Laboratories cannot be booked for lectures, which must be delivered in a classroom.	
3. If a certain lab is required outside scheduled time, a booking request must be filled and submitted to the Laboratory Manager for coordination and reservation.	
4. Any booking cancellation should be reported to the Laboratory Manager.	
5. When using the anatomy lab; the anatomical donors must be always treated with the utmost respect.	**Anatomy Personnel**

6.	A full-time anatomy instructor must be present when students study a cadaver at all time.	
7.	The cadavers are primarily for demonstration. Students shall not touch or dissect a cadaver unless specifically directed to do so by a full-time anatomy instructor.	
8.	Disposition of Cadaver parts must be implemented according to the Disposition of Cadaver Policy.	
9.	Anatomy lab is restricted area, only authorized personnel can access the suite.	
10.	Mannequins in the Skill Lab are kept in the bed or on the chairs. Mannequins should not be moved unless it is part of the skill assignment.	**Clinical Instructor/ Teaching Assistant**
11.	Students shall extend the same respect afforded to real patient to mannequins and simulators.	
12.	Only pencils are permitted in the clinical skills lab with models and mannequins.	
13.	Betadine should not be used on the manikins or the training models.	
14.	Laboratory supervisor assigned for a specific course is responsible for preparing the lab requirement before the practical session.	**Laboratory Supervisor**
15.	The lab instructor who booked the lab should be in the lab at least 15 minutes prior to the session to ensure that the lab have been arranged properly and should make sure that all used equipment is cleaned and kept in the proper place.	
16.	Lab instructor/teaching assistant must return all used supplies to its original place and ensure that the lab is kept neat and tidy for the following practical session.	
17.	Lab instructor/teaching assistant is responsible for preparing/borrowing the needed equipment according to the conducted experiment one day ahead of the practical or clinical session.	
18.	Lab instructor /teaching assistant should shut down the audiovisual system used after the session has been completed.	
19.	Personnel should exercise safe working practice. Chemicals should be handled with suitable caution.	

	20. Lab supervisor should update the lab inventory list after the end of each semester and send a request for any consumables/reagents beforehand to LM to avoid any shortage during the upcoming practical sessions.	
	21. Course coordinator wish to borrow an equipment asset must fill and completed the borrowing form and submitted to the laboratory supervisor in charge of the laboratory.	
	22. Copies of the borrowing form must be completed by course instructor and signed as well then submitted to the laboratory Manager	
	23. If anyone wish to transfer an asset for a valid reason, the asset transfer from must be completed and submitted to the laboratory manager	
	24. Health and safety regulations must be applied according to national regulations.	**Safety and Security Manager**
	25. Laboratory booking for extra session will be arranged through the Laboratory manager or the laboratory supervisor in charge of the lab	**Laboratory Manager**
	26. Training session for new equipment and new mannequins will be arranged with the responsible supplier and biomedical engineers and course coordinator/instructor will be informed with the full information regarding the time of the training and location.	
	27. A comprehensive inventory list of all laboratories will be updated annually and send to MBBS Program Director and laboratory supervisor/clinical instructors.	
	28. Any malfunctioning of any laboratory instrument must be reported to the laboratory manager and will be reported and handled by the DSFH biomedical engineers or concerned outsourced department.	
	29. Any Course Coordinator/Laboratory Supervisor wish to request for a laboratory consumables and reagents should submit the request to the laboratory manager through an official email for proper processing.	
	30. The laboratory utilization and operation will be inspected regularly.	

31.	Laboratory biohazard and chemical waste segregation will be monitored by the laboratory supervisor and will be disposed under the supervision of Laboratory Manager in adherence to the Management and Disposal of FCMS Laboratory Waste Policy.	
32.	Any Asset transfer will be reported to BME and PC Department.	
33.	Students are not permitted to practice any lab experiment without the presence and supervision of the lab instructor. In case they require extra session, a laboratory supervisor must be present while they are practicing.	**Students**
34.	Students must always wear their ID while dressing in the appropriate college dress code.	
35.	No eating, drinking, or smoking is allowed inside the laboratories.	
36.	No photography or videos of any type is allowed inside the laboratories.	
37.	No cell phones are allowed during practical/clinical sessions.	
38.	Students are not allowed to sit or put any personal items inside the lab.	
39.	Students shall not move any equipment inside the lab.	
40.	Students will be responsible for any damages caused to the equipment/mannequin they used.	
41.	Students are not permitted to enter lab storeroom or stockroom.	
42.	Students should report pregnancies, physical disabilities, recent injuries, illnesses, surgeries, or communicable diseases to their instructors as soon as possible so that necessary precautions may be taken.	
43.	Report any incident, damage, or problems to the lab supervisor.	

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-07	
Policy Title: Academic Quality Monitoring and Evaluation	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	1. To maintain and improve stakeholder's expectation and satisfaction over the quality of academic services provided by MBBS program at FCMS. 2. To ensure that the students receive high quality education and training through well-structured MBBS program.
Policy	1. FCMS is committed to maintain and improve the quality of MBBS Program, its facilities and activities all the time. 2. Consideration is given to the inputs, processes and outcomes, with an emphasis on the quality of teaching and learning and services it provides. 3. FCMS always focus on improving the quality of MBBS program and its services by gathering regular feedback from faculty, students and stakeholders to identify areas for improvement. 4. FCMS is committed to utilize various mechanisms to collect and evaluate feedback on the academic quality of MBBS Program such as course evaluation, students experience survey, MBBS program evaluation survey, student's satisfaction survey, intern's satisfaction survey, and employer satisfaction survey. 5. For MBBS program, a specification should be prepared and ensure that its mission and objectives are aligned with FCMS mission and vision. 6. The development of MBBS Program Specification, Course specification and Field experience specification and its corresponding Reports has to comply with the guidelines of National Commission for Academic Assessment and Accreditation (NCAAA). 7. Specific Key Performance Indicators are selected by MBBS Program for monitoring and reporting its quality. 8. A comprehensive review of the MBBS Program specifications is conducted every 5-7 years according to FCMS Policies and Procedures. 9. Operational plan/ Improvement plan for MBBS Program will be prepared considering the recommendations from previous year Annual Program report, Course report, Field Experience Report and Survey Reports.

Procedure		
	Procedure steps	**Responsibility**
	1. Completion of Program Specification, Courses Specification and Field experience specification and its corresponding Reports	
	1.1. Preparation of MBBS Program Specification by program director to be reviewed by Curriculum Review and Learning Outcome Monitoring Committee (P-CRLOMC) and MBBS Program Steering Committee (MPSC) as well as the MED in order to make adjustments where necessary.	**Program Director**
	1.2. Course Specifications are prepared by the Course Coordinator and reviewed by program director and by using course specification checklist, and MED adjusting when necessary.	**Course Coordinator**
	1.3. Field Specification for MBBS bachelor's degree Program is applicable for Internship Year and it will be prepared by the Internship Coordinator and by the Internship and Clinical Training Committee (P-ICTC) then discussed in the MPSC, Institutional Internship and Student Training Committee (I-ISTC) and MED making adjustments where necessary.	**Internship Coordinator**
	1.4. The final version of MBBS Program Specification, Course Specifications and Field experience Specification will be compiled and submitted to the Vice Dean for Development and Quality Management (VDDQM). The VDDQM will submit to MED for review and then to MPSC for approval.	**Program Director**
	1.5. The MED submits the final revised Program Specification, Course Specifications and Field experience Specification to Quality and Accreditation Unit (QAU).	**MED**

1.6.	QAU submits the final revised Program Specification, Course Specifications and Field experience Specification to the program director.	**QAU**
1.7.	MBBS program director will publicize the approved Program Specification, Course Specifications and Field experience Specification to faculty members.	**MBBS Program Director**
1.8.	At the end of each semester each course instructor is responsible to prepare the Course Report.	**Course Instructor**
1.9.	Course Coordinator is responsible for reviewing the Course Reports and compiles it into a single Course Report if the Course is offered in more than one section.	**Course Coordinator**
1.10.	Course Coordinator has to submit the Course Reports to program director within three days of the final exam of the course.	**Course coordinator**
1.11.	The completion and accuracy of the course reports will be checked by using the course report checklist by HOD.	**HOD**
1.12.	Course reports following the complete review by HOD submit to the MBBS program director.	**HOD**
1.13.	Course reports following the complete review by program director and reviewing by P-CRLOMC and MPSC are submitted to VDDQM and MED respectively.	**Program Director**
1.14.	The submitted course reports are finally reviewed by MED staff members to be completed and submitted to QAU with 7 days of receipt.	**MED**
1.15.	Field Experience Report has to be completed by the Internship Coordinator within 2 weeks of completion of the Internship Year and submit to P-ICTC and MPSC for review and feedback.	**Internship Coordinator**
1.16.	Considering the feedback through all these course reports and field experience report, program director will write an	**MBBS Program Director**

	Annual Program Report at the end of each academic year.	
1.17.	The completion and accuracy of the specifications and reports will be checked by using the course specification checklist and course report checklist by the program director. (See attachment)	**MBBS Program Director**
1.18.	MBBS program director has to discuss the Annual Program Report at the MPSC and will forward to MED, Institutional Curriculum Review and Monitoring Committee and Quality and Accreditation Steering Committee (QASC) for revision. After reviewing the documents, the final report will be submitted to the College Council for approval.	**MBBS Program Director**
1.19.	The final version of annual program report, Course reports and field experience report will be compiled by the MBBS Program Director and sent to the VDDQM. The VDDQM will submit to MED for review	**MBBS Program Director**
1.20.	After review, the final reports will be submitted to the College Council for approval.	**College Council**
1.21.	The MED will submit the final revised annual program report, Course reports and field experience report to QAU.	**MED**
1.22.	The QAU will submit the final revised annual program report, Course reports and field experience report to the MBBS Program Directors.	**QAU**
1.23.	Program director will publicize the approved annual program report, Course reports and field experience report to faculty members.	**MBBS Program Director**
1.24.	The final version of annual program report, Course reports and field experience report will be compiled by the concerned Program Director and sent to the VDDQM. The VDDQM will submit to MED for review.	**MBBS Program Director**

1.25.	The MED has to submit the revised Program report, Course reports and field experience report to the Quality and Accreditation Unit at the end of each Academic Year.	**MED**
2. Stakeholders' Evaluation on quality of academic programs and services		
2.1.	The evaluation of quality of Courses offered is monitored by surveys like Course evaluation survey done by students and staff at the end of each course, Students experience survey done by level -6 students and MBBS Program evaluation survey is conducted by the graduating students. (See attached survey formats).	**QAU**
2.2.	Stakeholder surveys also will be conducted at the end of each academic year to monitor the quality of MBBS program. (Employer satisfaction survey, Staff satisfaction survey, Students' satisfaction survey)	**QAU**
2.3.	The quality evaluation survey feedback will be forwarded to the MBBS program director and a copy will be kept in Quality and Accreditation Unit.	**QAU**
2.4.	Quality and Accreditation Unit Director will review the reports to identify the gaps and areas for improvement and return to the program director for a plan for improvement.	**QAU**
2.5.	Quality and Accreditation Unit will follow up the improvement plan with the concerned and provide final report to the Quality and Accreditation Steering Committee (QASC).	**QAU**
3. Completion of Course portfolio		
3.1.	Course portfolio is to be prepared for each course by course coordinator at the end of each semester and submitted to HOD for review.	**Course coordinator**
3.2.	Course Coordinator must submit the Course portfolio to the concerned HOD	**Course Coordinator**

	within two weeks of publishing the final exam result according to FCMS academic calendar.	
3.3.	The concerned HOD must submit the course portfolio to the Program Director for review and feedback	**HOD**
3.4.	MBBS Program Director must submit these course portfolios to the QAU at the end of each semester.	**HOD**
4. Monitoring the Action plans in course Report and Annual program Report:		
4.1.	Monitoring the action plan is the shared responsibility among MPSC, MED and IQAS.	**MPSC, MED and IQAS**
4.2.	Upon approval of the course reports, program director compile all the action plans of the offered courses and discuss it in the MPSC.	**MBBS Program Director**
4.3.	MBBS Program Director are responsible to report the progress on achievement of the action plans (from course report and annual program report) on monthly basis to the MED.	**MBBS Program Director**
4.4.	MED is responsible to review the action plans on monthly basis and provide necessary feedback and directives in order to ensure the achievement of planned actions within the stipulated time frame.	**MED**
4.5.	IQAS (Internal Quality Assurance System) team will review the compliance of the action plan monitoring process and report its findings to QASC on semester basis.	**IQAS**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-08	
Policy Title: Students' Poor Academic Performance Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	The purpose of this policy is to identify students with inadequate academic performance and implement strategies for assisting students to achieve academic success.
Policy	1. MBBS program is committed to identify students with poor academic performance and support their academic progress to assist them to successfully complete their courses. 2. If the student receives three consecutive academic warning letters for having a cumulative GPA lower than 2.00 out of 5.00, or 1.00 out of 4.00 will be dismissed from the College. 3. The College Council (CC) may grant a fourth chance to a student who can improve his/her cumulative GPA by studying the courses available.

Procedure

Procedure steps	Responsibilities
1. <u>Throughout the course</u>	
1.1. Student academic performance is monitored closely to identify any student whose performance is likely to lead to academic failure.	**Course Coordinator**
1.2. Course coordinator will identify students who do not achieve 70% at least in two consecutive assessments in the course.	**Course Coordinator**
1.3. The course coordinator will set up a meeting with the student to support him/her to address issues affecting academic performance.	**Course Coordinator**
1.4. The course coordinator will provide the student with an academic progress form and individual feedback form (with action plan specified) and advise him/her on how to achieve the requirements for successful academic progression.	**Course Coordinator**

1.5. The MBBS Program director will refer the student to the academic advisor for consultation.	**MBBS Program director**
1.5.1. If the student has difficulties in understanding the course materials, the academic advisor will organize extra tutorial hours for the student.	**Academic Advisor Course Coordinator**
1.5.2. The course coordinator will arrange a small teaching group according to student's needs.e.g English, Mathematics, ...etc.	**MBBS Program director**
1.5.3. If the student faces personal or psychological problems, it will be reported to the program director who will refer the student to the college's psychosocial counselor.	**MBBS Program director**
1.6. **<u>The psychosocial counselor will</u>**	
1.6.1 Set up meetings with the student to identify the causes of the problem and propose solutions to help the student to overcome these problems.	**Psychosocial counselor**
1.6.2 Send a report to the program director about the student's problem and implemented actions.	**Psychosocial counselor**
1.6.3 Student's academic performance will continuously be monitored by the course coordinator and the academic advisor. 	**Course Coordinator Psychosocial counselor**
2. **<u>At semester level</u>**	
2.1. At the end of each semester, the program director will discuss the exam results in the MBBS Program Steering Committee (MPSC).	**Program director MPSC**
2.2. The MPSC will check the course completion rate and identify students who failed or didn't achieve 70% in courses.	**MPSC**
2.3. The program director will refer poor performance students to the academic advisor	**Program director**

	to identify the causes of failure and provide advices for improvement.	
	2.3.1. The academic advisor will discuss the problem with the student and implementing the appropriate strategy according to student's problem as follows:	**Academic Advisor**
	2.3.2. English language problem: an extensive English Language course will be organized for the students in a convenient time.	**Academic Advisor** **English instructor** **Program director**
	• Weakness in mathematics: an extensive mathematic course will be organized for the students in a convenient time.	**Academic Advisor** **Math instructor** **Program director**
	• Difficulties in understanding the course materials: extra tutorial hours will be organized for the student.	**Academic Advisor** **Course instructor** **Program director**
	• Frequent absenteeism: the causes of absenteeism will be discussed with the student and appropriate solutions will be proposed accordingly.	**Academic Advisor** **Program director**
	• Teacher-student interpersonal relationship: the academic advisor will discuss the issue with both the instructor and student, and find solutions for improving their relationship.	**Academic Advisor**
	• Poor time management: the academic advisor will help the student to plan time and improve time management skills.	**Academic Advisor**
	• Non-motivated or non-interested in the course: the academic advisor will collaborate with the course coordinator to motivate the student.	**Academic Advisor**
	• Course coordinators and academic advisors will continuously monitor students academic progress and report to the program director.	**Course coordinators** **Academic advisors**
	2.4. For students whose semester grade point is below a 2.0:	
	2.4.1. The Registration Unit will send a report to the Program director.	**Registration Unit**

	2.4.2. A warning letter will be sent to the student by the Vice Dean for Academic Affairs (VDAA).	**Registration Unit**
	2.4.3. The academic advisors who will set up a meeting with the student to discuss the causes of the problem and provide advices for improvement.	**Registration Unit**
	2.4.4. Students' progress in the following semester will be continuously monitored by the academic advisor and reported to the program director.	**Registration Unit**
	3. **<u>At program level</u>**	
	3.1. **Registration Unit will:**	
	3.1.1. Identify students whose cumulative GPA is below 3. 3.1.2. Send a report to the Program director and academic advisor	**Registration Unit**
	3.2. The Program director will discuss about the students whose cumulative GPA is below 3 in the MPSC.	**Program director**
	3.3. Follow up of the student's academic progress in the course/courses he/she is enrolled in will be continuously monitored by the course coordinator and the academic advisor, and will be reported to the Program director and Student Progress and Promotion Committee (SPPC).	**Program director SPPC**
	3.4. For students whose **<u>cumulative GPA is below 2:</u>**	
	3.4.1. The Registration Unit will send a report to the Program director.	**Registration Unit**
	3.4.2. A warning letter will be sent to the student by VDAA.	**VDAA**
	3.4.3. The Program director will discuss students whose cumulative GPA is below 200 out of 5.00 in MPSC.	**Program director**
	3.5. The recommendation will be submitted form MPSC to the Academic affair Committee (AAC).	**MPSC**
	3.6. The recommendation of the AAC will be forwarded to the College Council for final decision.	**AAC**

	3.7. The College Council decision will be sent to the Board of Trustees (BOT) for ratification.	**CC**
	3.8. The Registration Unit will inform the student of his/her dismissal and cancels his/her enrollment.	**Registration Unit**
	3.9. A dismissed student is required to obtain a clearance through the Admission Unit.	**Admission Unit**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-09	
Policy Title: Student Academic Appeal Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version was Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	The policy aims to ensure fairness and rigorous quality assurance of the academic decision-making processes. The policy seeks resolution when a student feels that he/she has not been treated fairly with respect to academic decisions. Student appeals provide a mechanism for reasonable review of academic decisions.
Policy	1. MBBS students have the right to appeal for a review of an academic decision on assessment, progression and termination of studies. 2. The college encourages students and staff to resolve academic issues through discussion. When resolution is not reached, students may request for formal review. MBBS program believes that it is our responsibility to maintain academic integrity. 3. The student may appeal against the final grade of the course within a period not exceeding fifteen days from the announcement of the result. 4. The student may appeal against grade within a course or academic decision within a period not exceeding five working days. 5. The student first attempts to discuss the academic issue with the instructor of the course within five working days of receiving a grade or an academic decision. 6. Academic Decisions that may be Appealed: 6.1 A final grade in a course. 6.2 A grade within a course (e.g. written exam, oral presentation, written assignment, skills lab, practical exam). 6.3 An academic dishonesty charge (e.g., plagiarism, cheating). 6.4 Student denial of entry test. 6.5 Termination of studies. 6.6 Other issues related to academic decisions. 7. Grounds for Appeal 7.1 Merit of work (an academic decision that does not reflect student's achievements). 7.2 Illness/ hospitalization. 7.3 Personal issues (e.g. death of a family member, legal issue, unexpected circumstances). 7.4 Policy violation (when a staff fails to follow college policy and procedures which affects student's academic grade). 8. Privacy and confidentiality will be maintained throughout the appeal process.

	9. Disclosure about the appeal will only be made if it is necessary for dealing with the appeal and ensures that the student is protected against subsequent punitive action or discrimination following the appeal.

Procedure	Procedure Steps	Responsibilities
	1. The student first attempts to discuss the academic issue with the instructor of the course.	**Students** **Course instructor**
	2. If the issue remains unresolved, the student discusses the problem with the academic advisor.	**Students** **Academic Advisor**
	3. If the issue is not resolved and the student remains dissatisfied with the academic decision, then the student may commence a formal appeal in accordance with the academic appeal policy of FCMS and procedures of MBBS program.	**Students**
	4. The student fills out a 'Student Appeal Form' (Annex 1).	**Students**
	5. The student can attach evidence that support the appeal.	**Students**
	6. The student pays the appeal fees (50 Saudi Riyals) in case if it necessitates an exams grade review process.	**Students**
	7. The student submits the completed 'Student Appeal Form,' supported evidence and fees receipt to the Vice Dean Academic Affairs (VDAA) through academic advisor to complete the further steps.	**Students**
	8. The VDAA submits the appeal form to the Academic Integrity and Appeal Committee (AIAC) for further investigation and recommendation.	**VDAA**
	9. The AIAC sets up a meeting with the student and involved staff members within 5 working days of receiving the appeal.	**AIAC**
	10. The AIAC discusses possible alternatives for resolving student's appeal.	**AIAC**
	11. The AIAC takes a decision and submits the decision to the Dean for approval.	**AIAC**
	12. The VDAA communicates the decision in writing to the student (through academic advisor) within 7 working days of receiving the appeal.	**VDAA**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-10	
Policy Title: Faculty Office Hours Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version was Approved on: 15-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	To achieve the college goals, and provide students enrolled in Bachelor in Medicine, Bachelor of Surgery (MBBS) program with maximum direct access to all MBBS faculty staff, for consultation and advise during office hours. This policy developed for effective use of office hours dedicated to improve the student engagement with academic staff outside the regular Hours.
Policy	1. MBBS program director is responsible to inform all MBBS faculty staff members regarding this policy and its regulation. 2. The office Hours policy is developed for seeking advice, counseling and for academic instruction outside of the classroom for students by faculty staff members. 3. Students should be informed of any necessary deviations from posted office hours.
Procedure	

Procedure Steps	Responsibility
1. The office Hours are implemented within the first week of academic calendar and will be outside of the regular schedule.	**Course instructor**
2. Approximately for each course 2 to 3 office hours per week are required and posted on the staff member's respective door to inform students when he/she will be available for advising and consultation during the office hours and mentioned during the introductory lecture (1 hour) the course by the course coordinator.	**Course instructor/Coordinator**
3. Whenever a faculty member is not available or similarly occupied, as for example in academic meetings, she/he must inform the student and reschedules another time with them.	**Course instructor**
4. The Faculty staff members shall notify the MBBS Program director when they are unable to keep established office hours for re-arrangement.	**Course instructor**

	5. The MBBS Program director are responsible for ensuring that the office hours are reasonably accommodating to student needs within the context of each faculty staff member's schedule.	**MBBS Program director**
	6. Student feedback must be collected annually by the Quality and Accreditation Unit (QAU) regarding the office hour for more improvement.	**QAU**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-11	
Policy Title: MBBS Faculty Staff Workload Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version Approved on: 15-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	To ensure that all faculty members fully achieve their performance expectations.

Policy

1. The distribution of workload assignments for an academic faculty member will be determined in accordance with MBBS Program Mission and goals.
2. It is the responsibility of the Head of Department (HOD), under the oversight of the College Dean, to make workload assignments to MBBS faculty members.
3. All faculty members are expected to perform department and/or college services as needed including administrative, academic advising and other activities.
4. Teaching:
   The following table outlines the teaching workload that also covers other academic activities within FCMS:

Academic rank	Credit Hours/Semester
Professor	14
Associate professor	14
Assistant professor	16
Lecturer	18
Language teacher	18

The teaching workload include the following:

Teaching Activity	Contact Hour	Credit Hour
Theoretical sessions/ interactive lectures / SGD/ PBL/ TBL/ FC/FA	1.5 contact hr per week for 13 weeks	1 CH
Lab /practical sessions/tutorials.	3 contact hrs per week for 13 weeks	1 CH
Clinical training sessions.	4.5 contact hrs per week for 13 weeks	1 CH

The College Council has the right to approve for any extra teaching credit hours. Faculty with approved teaching workload assignment must continue to fulfill

community service and research obligations. Other academic activities will be considered as part of teaching and learning as long as the evidence are produced as per this policy.

5. Scientific research and scholarly activities:

Research projects approved by College Dean and funded by FCMS or other agencies only will be considered.

Academic rank	Credit Hours/Semester	Scientific research contact Hrs./ semester
Professor	4	60
Associate professor	4	60
Assistant professor	2	30
Lecturer	2	30

Scientific Research activities (conducted or approved by FCMS) include the following:

- Publish a scientific paper (a minimum) in peer-review journal per semester.
- Writing or translating a peer scientific book.
- Oral presentation of scientific paper in a scientific conference.
- Preparing a scientific proposal (funded within the academic year).

- Supervising post-graduate dissertations (2 CH for MSc, 4CH for PhD per Semester).
- Two-months at the end of the academic year (July and August) is devoted for research activities.

6. **Community Engagement:**

The activities performed within the scope of approved Community service plans only will be considered under this section.

Community services contact Hrs/ semester	Credit Hours /Semester
60	2

The Community service activities include all volunteering activities and participating in actual community engagement activities within the scope of FCMS community service plan:

- School Awareness Program
- International Schools Visit Program
- Vaccination Campaign Program
- International Awareness Days
- Charity Visits Program

- Patient awareness and health education
- Collaborative activities with government, private organizations.
- Presenting community education programs to the public.

7. **Administration Responsibilities:**

Teaching workload is reduced for any MBBS Program staff member assigned for administration work, such as Dean, Vice Deans, Head of Departments and Directors, to do their administration responsibilities.

Admin. Level	Administrative workload (credit hours per semester)
Dean	8
Vice Deans	4
Head of Departments (HODs)	4
Program Director	4
Year coordinator	2
Unit manager	2

8. **Professional Service**

All MBBS Program teaching staff are expected to engage in professional, discipline-specific, and institutional/departmental service activities including working under license in any of the clinical departments or units at DSFH or equivalent sites: this should exceed more than 2 CHS per semester, unless it is, indicated otherwise in the contract.

9. **Overall workload for teaching staff (credit hours per semester) as per MOE guiding lines:**

Academic rank	Teaching & Learning	Research	Community Service	Professional
Professor	14	4	2	2
Associate Professor	14	4	2	2
Assistant Professor	16	2	2	2
Lecturer	18	2	2	2
Language Teacher	18	N/A	N/A	2
Administrative workload will be added (if available)				

Procedure

Procedure Steps	Responsibility
1. Teaching staff workload must be finalized by the concerned HODs minimum one month before the starting date of the upcoming semester.	**HOD**
2. According to the approved departmental workload each teaching staff member must prepare their individual teaching workload (see Annex-1) and submit it to the HOD (of the department where they belong to).	**Teaching Staff Member**
3. Each HOD must submit their departmental staff 'Individual teaching Workload' to the Director of the Program and then to the Dean for review and approval.	**HOD**
4. It is the responsibility of each HOD to ensure that the responsibilities are distributed fairly among all departmental staff members according to their specialization and capabilities to facilitate the smooth functioning of the department as well as all program offered within the College.	**HOD**
5. Evidence needs to be provided for all Research, Community service, and other activities according to this policy.	**HOD**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-12	
Policy Title: MBBS Students Assessment Plan and Management Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	1. To ensure that the student assessment process is in compliance with CUAs regulations and FCMS and MBBS policies and bylaws. 2. To ensure that the assessment process is valid, reliable, comprehensive and fair. 3. To confirm that assessment plan includes direct and indirect assessment methoc contributing to an effective achievement of students' learning outcomes in the MBBS program. 4. To ensure continuous monitoring, verification and quality assurance of the assessment process and outcome. 5. To ensure appropriate security of exam content and blueprint as a substantial element for maintaining the confidentiality and integrity of the exams.
Policy	1. MBBS program is committed to enhance the entire educational process based on effective management of the assessment process. Assessment provides an academic standard that ensures continuous monitoring of student's achievement of learning outcomes. This policy provides a structured framework for planning, implementation and monitoring of assessment in MBBS program.

Procedure

Procedure steps	Responsibility
1. **Planning process (Pre-examination)**	**Dean**
1.1. Refer to mission statement.	
1.2. Revise students learning outcomes (SLOs), Course Learning Outcomes (CLOs) and Program Learning Outcomes (PLOs).	**MBBS Program Director**
1.3. Plan for revising and implementing assessment policies.	**MBBS Program Director Assessment Centre (AC)**
1.4. Plan for Direct assessment (Identify methods and measures for direct assessment).	**MBBS Program Director AC**
1.5. Plan for the implementation of assessment process.	**MBBS Program Director AC**

	1.6. Plan for the analysis and Report of results.	**MBBS Program Director** **AC**
	1.7. Student Notification of the Form of Assessment.	**MBBS Program Director** **Course coordinator**
	1.8. Pre – examination for summative assessment (Prepare blue print -Design Item and review them).	**Course coordinator** **MBBS Program Director** **AC**
	1.9. Preparation of Indirect Measures of assessment	**AC** **QAU**
	2. **Implementation of assessment (During Examination)**	
	2.1. All examinations must be taken within the schedules that are announced by the Examination Committee.	**Examination Committee**
	2.2. The course coordinator submits the sealed exam questions to the head of department (Set-1 and Set-2, with key answer and course blueprint) at least 10 days before the scheduled date of examination.	**Course coordinator**
	2.3. Marking and auditing of exam papers should be conducted in the control room to ensure the security of exam papers.	**Examination Committee**
	2.4. Course coordinator should mark exam papers and enters the marks achieved by the students in the result sheets prepared for that purpose.	**Course coordinator**
	2.5. Grading Elements: Students are required to achieve a minimum Grade Point Average (GPA) of 2.0 at each level in each course (out of a possible 5.0); if they fail to achieve this level, they do not pass and must retake the course. GPA is determined by dividing the total number of points from all the courses the student has attended by the number of units in the student's schedule.	**MBBS Program director** **Course coordinator**

3. **Cumulative Grade Point:** — **Course coordinator**

Cumulative Grade Point Average (GPA)	Grade
Greater than 4.50	Excellent
3.75 < 4.50	Very Good
2.75 < 3.75	Good
2.00 < 2.75	Pass
Less than 2.00	Fail

4. **Grading System** — **Course coordinator**

Grade	Numerical	Average Point
A+	95-100	5.0
A	90-less than 95	4.75
B+	85-less than 90	4.5
B	80-less than 85	4.0
C+	75-less than 80	3.5
C	70-less than 75	3.0
D+	65-less than 70	2.5
D	60-less than 65	2.0
F	Below 60	1.0

5. **Verification and analysis (Post – examination):**

5.1. **Post –examination-Level-1**

5.1.1. **Quality Assurance, Verification and Review**: Assessment tasks must be subjected to routine assessment verification processes and review through consensus verification practices.	**AC**
5.1.2. **Audit:** Examination Committee will assign faculty staffs to review the examination process in each course to ensure that they reflect appropriate assessment design and grading.	**Examination Committee AC**
5.1.3 **Internal Verification:** Assessment subcommittee will verify the student male and female result.	**MBBS Program Director, AC and External verifiers**
5.1.4. **External Verification:** External examiner from other local universities will attend examination procedures and verifying students result by using specific checklist (External Examiner Report).	**Examination Committee**

	5.1.5. The Examination Committee is responsible for auditing the calculation of the student's grades to ensure the accuracy of its calculation and comparing it with that in college website then submitting the verified exam results to the course coordinator.	**Course Coordinator** **MBBS Program Director** **VDAA** **AC & QAU**
	5.1.6. **Signature and approval:** Course coordinator should sign the result sheet and approve it from the Head of the Department -after it is discussed and approved in the MBBS Program Steering Committee (MPSC), then the results are approved by the College Council and released to students through the PeopleSoft	**AC** **QAU** **MPSC** **CC**
	5.1.7 KPIs: (Process and outcome).	**QAU**
	5.1.7.1. Analysis: Item analysis and writing analysis report.	**AC**
	5.1.8. Indirect assessment (already prepared before) are distributed (Surveys for students, staff, employers) and analyzed.	**QAU**
	5.2. **Post-examination - level-2**	
	5.2.1. Course reports and course portfolios are prepared (including samples of all assessment methods e.g. MCQs, assignments, OSCE, OSPE etc.).	**Course coordinator**
	5.2.2. All course reports including any analysis of the whole semester educational process (teaching and assessment processes, resources and action plans for improvement) should be submitted to the Head of the Department and discussed in MPSC meeting.	**Course coordinator** **HOD**
	5.2.3. Annual program report should be written -based on all included course reports- and discussed in MPSC meeting.	**MBBS Program Director**
	5.2.4. Annual program report is submitted to Medical Education Department (MED), Curriculum Reviewing and Monitoring	**MBBS Program Director**

		Committee (CRMC) and College Council (CC) to be approved.	
	5.2.5.	Action plans prepared for improvement are used in planning process for the new academic year.	**MBBS Program Director**
	5.2.6.	The IQAS monitors the implementation of these action plans, thus closing the loop.	**IQAS**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-13	
Policy Title: Writing Multiple Choice Questions (MCQs) Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Last Version Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	1. To define the rules and regulations of writing MCQs in all written exam for MBBS program in FCMS. 2. To ensure that MCQs included in written examinations in MBBS program are well written according to international guidelines developed for this purpose. 3. To support academic staff members in MBBS to check the quality of the questions, they wrote for different exams.
Policy	1. This policy and its associated checklist apply to all written examination conducted in MBBS program. It sets out the guidelines and roles for academic staff to properly write MCQs in their exams.

Procedure

Procedure steps	Responsibilities
MCQs writing guidelines:	
1. **Guidelines for the whole item:**	
1.1. The item reflects an important curricular objective.	**Course instructors Program director Assessment center (AC)**
1.2. The item focuses on a single problem.	
1.3. The item is totally independent of all other items for its correct answer.	
1.4. The item should be free of cultural, gender, or other biases	
1.5. The item is not unduly demanding of the student's total time for the test.	
1.6. The item should be clear and contain simple language.	
1.7. Asking opinion was avoided type questions	
1.8. Whole item is on same page.	
2. **Guidelines for writing stem:**	
2.1. The stem should be self-contained, the students should be able to answer the question without reference to the alternatives (e.g. follow the rule of "cover the options".	**Course instructors Program director AC**

	2.2. The stem should be clearly worded and free of ambiguity.	
	2.3. The stem should be free of irrelevant or unnecessary detail.	
	2.4. The stem asks a question that has a definite answer	
	2.5. The stem should not provide grammatical clues to any alternative	
	2.6. Negatively worded stems should be avoided if possible (e.g. except and not).	
	2.7. All questions have the same number of alternatives.	
	3. **Guidelines for writing alternatives**	
	3.1. The alternatives are all appropriate to the question asked or implied by the stem	**Course instructors** **Program director** **Assessment center**
	3.2. Alternatives must be grammatically consistent with the stem.	
	3.3. Alternatives should be in one column.	
	3.4. Avoid overlapping distracters (e.g. in range values).	
	3.5. Alternatives are stated as briefly and simply as possible.	
	3.6. Words common to all the alternatives should be placed in the stem.	
	3.7. All distracters should be plausible, attract the marginal student to choose them.	
	3.8. The use of trickery has been avoided.	
	3.9. "All of the above" is not to be used.	
	3.10. "None of the above" is not to be used.	
	3.11. Key words from the stem are not repeated in the alternatives.	
	3.12. Avoiding stating the correct answer in greater length.	
	3.13. Avoiding absolute terms like "always" "never".	
	3.14. Avoiding stating the correct answer in textbook language.	
	3.15. False information in alternatives is not to be presented in the questions.	

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-14	
Policy Title: Assessment of Learning Outcomes (LOs)	☐ New	☑ Revised
	Version-1 was Prepared on: 12-10-2017	
	Version-2 is Approved on: 21-4-2022	
Applicable to: MBBS Program	**To be Reviewed on: 21-4-2027**	

Statement of the Purpose	1. To identify the rules and regulations of Assessment of Learning Outcomes (LOs) in all programs offered by FCMS. 2. To define the roles and responsibilities of all concerned parties involved in the process of LOs Assessment. 3. To determine the deadline for each step of the LOs assessment process.
Policy	1. This policy and its associated framework is applied to all educational program in FCMS with the aim to assess the achievement of LOs of each program and to close the loop of LOs Assessment.

Procedure

Procedure steps	Responsibility
1. **Plan Phase**	
1.1. Ensuring alignment of "Program goals and Learning Outcomes" with program and institution Missions.	**MBBS Program Steering Committee (MPSC)** **Program Director**
1.2. Ensuring PLOs alignment with program goals.	**Program Curriculum Review and Learning Outcomes Monitoring Committee (P-CRLOMC)**
1.3. Ensuring alignment of CLOs and SLOs with PLOs.	**Program Director, Course Coordinator, Medical Education Department (MED), P-CRLOMC**
1.4. Ensure alignment of teaching strategies with PLOs and CLOs.	**Program Director, Course Coordinator, Medical Education Department (MED),P-CRLOMC**
1.5. Selecting LOs to be assessed in each year.	**Program Assessment Committee (P-AC), P-CRLOMC, MPSC.**

1.6.	Selecting and reviewing the required KPIs according to national and international benchmarks.	**Program Quality Assurance Committee (P-QAC), Program Director, and Quality and Accreditation Unit (QAU)**
1.7.	Identifying the methods for "Direct and Indirect Assessment" in alignment with LOs.	**P-AC, Assessment Centre (AC), QAU**
1.8.	Preparing for Indirect assessment measures: (surveys for students, staff, and employers) and selecting methods of data analysis.	**P-QAC, QAU**
1.9.	Pre-examination preparation for summative assessment (test blueprint, developing items).	**Course instructor, P-AC, AC**
2.	**Do Phase**	
2.1.	Submitting exam papers set1and set 2, key answer and blueprint at least 10 days before the scheduled date of examination.	**Course Coordinator**
2.2.	Organizing control room and prepare electronic machine and answer sheets.	**Examination Committee**
2.3.	Conducting the examination according to schedule and FCMS regulation.	**Examination Committee**
2.4.	Mark exam paper Electronically or manually when needed.	**Course Instructor/ Coordinator** **Examination Committee**
2.5.	Distributing and collecting all course related questionnaires and surveys.	**QAU**
3.	**Check Phase**	
3.1.	Preparing Item Analysis report for written exam.	**P-AC** **AC**
3.2.	Discussing Item Analysis reports with concerned course instructors.	**AC** **P-AC**
3.3.	Completing the internal and external verification process for final exams.	**AC, P-AC**
3.4.	Uploading the scores on Peoplesoft by Course instructors.	**Course Coordinator**
3.5.	Approving the results in departmental meeting.	**HOD**
3.6.	Approving the results by Student Grade review and Moderation Subcommittee and College Council.	**Student Grade review and Moderation Subcommittee and College Council.**

3.7.	Publishing the approved results to students by Vice Dean for Academic Affairs (VDAA).	**VDAA**
3.8.	Students' appeal for grade review. (if any)	**VDAA**
4.	**Analysis and reporting Phase**	
4.1.	Submitting Course reports and course portfolios to HOD.	**Course Coordinator**
4.2.	Discussing the main data of course reports in departmental meeting and approving the suggested action plan.	**Course Coordinator**
4.3.	Submitting all course reports to Medical Education Department (MED) for revision.	**Program Director, VDDQM MED**
4.4.	Preparing annual program reports based on the data from course reports and approving it in departmental council.	**Program Director**
4.5.	Submitting approved program reports to MED for revision.	**Program Director, VDDQM MED**
4.6.	Preparing PLOs & CLOs achievement reports by Program director using attached forms. (5.2&5.3)	**Program Director Course Coordinator**
4.7.	Setting plan for closing assessment loop.	**AC**
4.8.	Communicating results of Learning Outcomes assessment and plan with faculty staff members.	**Program Director, HOD**
4.9.	Implementing plan for closing assessment loop.	**Program Director, Course Coordinator, AC**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-15	
Policy Title: Standardized patients	☐ New	☑ Revised
	Version-1 was Prepared on: 11-8-2021	
	Version-2 is Approved on: 10-8-2024	
Applicable to: MBBS Program	To be Reviewed on: 10-8-2029	

Statement of the Purpose	1. To provide an overview and outline for standardized patient sessions and logistics. 2. To provide students with the useful opportunity to observe, practice, and interpret in a safe environment through structured standardized sessions. 3. To provide authentic experiences by teaching and assessing students using standardized patients (SPs).
Policy	1. To ensure that the setup and execution of the SPs sessions is conducted effectively. 2. To conduct successful SPs sessions through recruiting, training and guaranteeing the highest standards in the use of standardized patients. 3. To ensure the safety of the SPs and the confidentiality of the information. 4. To ensure the satisfaction of the students and SPs with the conducted sessions.

Procedure

Procedure steps	Responsibilities
1. **Before the standardized patient session:**	
1.1. **Identification and selection of the standardized patients:**	
1.1.1. The required cases are identified for each course by the relevant specialized faculty staff members and the Program directors in collaboration with the Medical Education Department (MED) based on the curriculum requirements and identified Learning Outcomes.	**Faculty staff members** **Program directors** **MED**
1.1.2. The identified Cases will be sent to Vice Dean of Clinical affairs (VDCA) to communicate with PED for selecting the SPs through accessing the International Statistical Classification of Diseases 10th Revision (ICD-10).	**Vice Dean of Clinical Affairs** **Patient Education Department (PED)**

		1.1.3. The PED will send the list to VDCA and specified clinical faculty member to filter the list according to the following requirements: • Age. • Gender. • Physical characteristics of the patient in alignment with learning outcomes. • Case requirements (case difficulty) and the level of students' experience. • Ability to master the role and personality of the case. • Ability to interact with the staff & students in a professional manner.	**Patient Education Department**	
		1.1.4. The SPs that match the prerequisites of a case are contacted throughout the PED for discussing the following requirements: • What is expected form SPs during the session. • The dates/times of the sessions. • The availability to attend the training and the sessions day/s. • The financial benefits.	**Patient Education Department**	
		1.2. The PED will filter identified SPs according to their availability and interest.	**Patient Education Department**	
		1.2.1. The SPs will sign a consent form upon their approval (Annex 1). The consent will be signed every session, even if repeated SP.	**Patient Education Department** **SPs**	
		1.3. **Time and location of SPs sessions:**		
		1.3.1. The program director with course coordinator and Head of Clinical Sciences Department will prepare the schedule for the SP sessions and send it to the PED.	**Program director** **Course coordinator** **Head of Clinical Sciences Department**	
		1.3.2. The PED is responsible to communicate with the SPs and informing them by the date, time and location of the sessions 3-5 days before each assigned session according to the schedule.	**Patient Education Department**	
		1.3.3. SPs should arrive promptly at the confirmed time.	**SPs**	
		1.4. **Cancellation of sessions**		

	1.4.1. If the scheduled session is cancelled, the program directors will inform the PED within 3-5 working days before the time of the session.	**Program director**	
	1.4.2. The PED will notify the assigned SPs within 24 hours or more.	**Patient Education Department**	
	1.4.3. If SPs are unable to keep their commitment, they must inform the PED within 24 hours or more.	**SPs**	
	1.4.4. High percentage of late arrivals, or cancellations will lead to exclusion of the SPs from the SPs Bank.	**Course coordinator Head of Clinical Sciences Department Patient Education Department**	
	1.5. **Payments and Benefits**		
	1.5.1. SPs will receive payment for each session (The duration of each session is 3 hours) and they are expected to stay for the entire duration.	**Head of Clinical Sciences Department Patient Education Department**	
	1.5.2. SPs will receive payment for attending the training sessions.		
	1.5.3. SPs who are late on session day will have their pay adjusted accordingly.		
	1.6. **Writing of Cases/Scripts:**		
	1.6.1. The assigned team will write the appropriate case scripts.	**Specialists on the topic (Clinicians) Course coordinator Program director**	
	1.6.2. Written scripts will be reviewed and approved	**Medical Education Department**	
	1.7. **Training:**		
	1.7.1. **Training of the SPs:**		
	1.7.1.1. The Clinical Training Unit (CTU) will be responsible for preparing and conducting the training sessions in collaboration with the Program directors, Vice Dean for Academic Affairs (VDAA) and VDCA.	**Clinical Training Unit Program directors VDAA VDCA**	
	1.7.1.2. The SPs should arrive on time to all training sessions.	**SPs**	
	1.7.1.3. If an SP does not attend the training session, he/she will not be allowed to participate in the sessions.	**Patient Education Department**	

		1.7.1.4. Training sessions materials (cases script, manuals, checklists) will be developed by the clinical staff members in collaboration with Course coordinator, program Director and MED.	**Clinical staff members Course coordinator Program Director MED**	
		1.7.1.5. The training sessions will be held for all SPs.		
		1.7.1.6. The training session will provide the SPs with the following information: • Type of sessions – teaching or assessment (OSCE) • Overview of SPs script. • how to portray the case scenario and ensure confidence and comfort. • Level of student. • how to reply appropriately to questions from students. • how respond immediately to inappropriate behaviors to maintain a safe environment • Expectations and Responsibilities of SPs (Annex 2)		
		1.7.1.7. Additional training may also be given where specific skills are required.		
		1.7.1.8. Time is allocated prior to each session to review the case with the clinical staff members.		
		1.7.1.9. SPs should not change their portrayal from that which they were trained on.	**SPs**	
		1.7.2. **Training of the Clinical staff and preceptors:**		
		1.7.2.1. Assigned Clinical staff and preceptors will receive training on the structure, logistics and expectations from the SPs session	**ICTU Program directors VDAA and VDCA.**	
		1.7.2.2. CTU will be responsible for preparing and conducting the training sessions in collaboration with the Program directors, VDAA and VDCA.		
		1.8. **Lockers**		
		1.8.1. PED will specify certain lockers for the SPs.	**Patient Education Department SPs**	
		1.8.2. The PED provides locks to the lockers.		
		1.8.3. SPs are only responsible for their own belongings.		

	1.9. **Professional Appearance and Dress Code**		
	1.9.1. SPs should be clean and well-kept.	**SPs**	
	1.9.2. Hair should be clean and combed; nails should be clean.		
	1.10. **Confidentiality**:		
	1.10.1. **SPs should:**		
	• Be oriented that all materials, procedures, communications, and other related information of the SPs session are confidential.	**Patient Education Department SPs**	
	• Respect that the copyright of all materials belongs exclusively to Fakeeh College for Medical Sciences (FCMS), and these materials must be kept confidential.		
	• Be oriented that information taken from students have to be kept confidential as well as any conversations you may hear between students, faculty staff members.		
	• Be oriented that the unauthorized use or sharing of FCMS materials with other parties will result in discontinuation of services.		
	• Sign the confidentiality agreement Form (Annex 3)		
	1.10.2. **Students should:**		
	• Keep all SPs information in confidence.	**Students ICTU**	
	• Sign Code of Conduct form.		
	2. **<u>During the SP session</u>**		
	2.1. The PED will receive the SPs and direct them to their destination (corresponding session)	**Patient Education Department SPs**	
	2.2. The SPs will attend the entire duration (3 hours).	**Patient Education Department SPs**	
	2.3. Implementing the SPs session: Each SPs session will be divided into 3 parts.		
	2.3.1. **First part (30-45 minutes):**	**Coordinator of the session Students SPs Clinical preceptors**	
	• Each Clinical staff member (coordinator of the session) will be assigned to 25-30 students.		
	• The session coordinator will discuss the expected Learning Outcomes with brief introduction about the case with the students and receive students input and expectations.		
	2.3.2. **The second part (1 hour):**		

		• The students will be divided into 3 groups (8-10 students in each group).		
		• Three SPs will be available, one in each group.		
		• Three Clinical preceptors will be available, one in each group for supervising the students and facilitate the session.		
		• The Clinical staff members (coordinator of this session) will monitor each group.		
		• The session with SPs will include: ➢ History taking ➢ Physical examination ➢ Professionalism ➢ Communication ➢ Differential diagnosis ➢ Interpretation of findings		
		• The SPs will share their medical histories as trained.		
		• The students will perform both history taking and physical examination skills.		
		2.3.3. **The third part (1 hour) (debriefing session)** The Clinical staff members will give debriefing to all students		
		2.4. **Food, Beverage and Electronics:**		
		2.4.1. Food and drinks are available in the specified place and can be consumed during the break time.	**Coordinator of the session Students SPs Clinical preceptors**	
		2.4.2. No food or drinks are allowed inside the SPs sessions.		
		2.4.3. No cell phones or other electronics can be used during SPs sessions.		
		2.5. **In Case of injury during the session:**		
		2.5.1. The SPs session should be stopped immediately if an injury occurs, and clinical staff member (coordinator of the session) should be immediately informed.	**Coordinator of the session Students SPs Clinical preceptors Program director**	
		2.5.2. If the SP is required to visit their doctor or be seen in the emergency department, the clinical staff member will inform the program director.		
		2.5.3. The program director will inform the PED to help the SP immediately.		

2.6.	**Detection of Findings in Standardized Patients:** During the session, if the students noted incidental physical finding, the following should be followed:		
2.6.1.	**An emergency finding requiring immediate medical attention** (e.g. elevated BP, etc)		
a.	The students will inform the clinical preceptors.	**Students**	
b.	The clinical preceptors will report immediately to the clinical staff member, who will report to the program director immediately.	**Clinical preceptors**	
c.	The program director will inform the PED to help the SP immediately.	**Program director**	
2.6.2.	**Non emergent findings which do not necessitate immediate medical attention (e.g. lump in abdominal area etc):**		
a.	The students reports the findings to the clinical preceptors, who then discusses this with the SP in confidentiality at the end of the session.	**Students**	
b.	The clinical preceptors will encourage the SP to seek the appropriate medical follow-up.	**Clinical preceptors**	
3.	**After the SP session**		
3.1.	Assess the students' satisfaction with the SPs sessions on weekly bases (Annex IV).	**Quality and Accreditation Unit Students**	
3.2.	Assess the standardized patient satisfaction with the session on weekly bases (Annex V).	**Quality and Accreditation Unit SPs**	
4.	**Quality Assurance and Improvement:** The Program director, VDAA and VDCAA will take multiple approaches through:		
4.1.	Direct observation during training sessions.	**Program director VDAA VDCAA**	
4.2.	Direct observation during SPs sessions.		
4.3.	Discuss the feedback forms with the concerned individuals.		
4.4.	Conducting focus group with students, Clinical staff and preceptors.		
4.5.	Conducting interview with the SPs.		
4.6.	Identify the gaps as soon as possible and develop action plan for improvement.		
4.7.	Monitor the implementation of the action plan for closing the loop of quality.		

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-16	
Policy Title: Clinical Training Facility Selection Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 11-8-2021	
	Version-2 is Approved on: 10-8-2024	
Applicable to: MBBS Program	**To be Reviewed on: 10-8-2029**	

Statement of the Purpose	This policy establishes specific criteria in selecting institutions (Hospital and other Healthcare Facilities) for the clinical training of students of the MBBS program.
Policy	1. The FCMS and the selected clinical placement (Hospital and other Healthcare Facilities) must have an approved signed agreement. 2. The following criteria must be met in the selected clinical placement in order to enter 3the agreement: • Must offer services of all specialties that covers the core concepts of clinical practice for undergraduate medical students according to the MBBS program specifications. • Can be a primary, secondary or tertiary healthcare facility (private or government). • Must have appropriate teaching rooms that accommodates the number of affiliates (undergraduate medical students). • Must be accredited by national or international accreditation agencies. • Must have qualified clinical preceptors to supervise students and follow their progress with appropriate preceptor student ratio. • Must have appropriate case mix and flow rate to provide adequate experience for students. • Must have a well-established infrastructure with all equipment needed to facilitate students' clinical experience. • Must provide hands-on training to the students. • Must have adequate place for discussion sessions and bedside teaching.
Procedure	

Procedure steps	Responsibility
1. The "MBBS Program Director" with the Vice Dean for Clinical Affairs (VDCA) identify possible institutions for clinical training of the MBBS students.	**MBBS Program Director VDCA**
2. The list of identified institutions is presented to the MBBS Program Steering Committee (MPSC) for discussion and will be forwarded to the FCMS College Council for final approval.	**MPSC**

	3. A team is formulated to audit clinical placement and ensure the suitability for training.	**MBBS Program Director** **Internship Unit Director** **Clinical Training Unit Director** **VDCA** **VDAA**
	4. The VDCA affairs will prepare the initial draft of the agreement stipulating the terms and conditions to be agreed upon by both parties.	**VDCA**
	5. The final draft will be signed by representatives of both parties.	**Dean** **VDCA**
	6. The formulated team will continue to monitor and review the selected clinical placements status for ensuring their compatibility with the required criteria and recommend modifications when needed.	**MBBS Program Director** **Internship Unit Director** **Clinical Training Unit Director** **HOD**
	7. Monitoring students' performance during clinical training, with following up students' feedback and identification of points of weakness for rapid corrective measures.	**MBBS Program Director** **VDCA** **Clinical Preceptors**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-17	
Policy Title: Clinical Assessment and Evaluation	☐ New	☑ Revised
	Version-1 was Prepared on: 11-8-2021	
	Version-2 is Approved on: 10-8-2024	
Applicable to: MBBS Program	To be Reviewed on: 10-8-2029	

Statement of the Purpose	1. To identify the rules and regulations of the clinical training assessment and evaluation process. 2. To outline the roles and responsibilities of all concerned parties involved in the implementation of the follow-up, assessment, and evaluation process. 3. To confirm that students' achievement verification practices are followed in the clinical training
Policy	1. Assessment of the clinical training must be designed to contribute to high quality student learning and underpin the development, delivery and quality assurance of student's training. Assessment should both help students learn (Formative assessment) and measure explicit evidence of their learning (Summative assessment). 2. Students clinical performance is supervised continuously by clinical preceptors (clinical supervisors). 3. Each clinical preceptor is assigned for a number of students (5-10 students) to evaluate their performance and ensure individualized feedback and training. 4. Evaluation should be a continuous process in which the student is informed regularly of progress both informally and formally during the clinical experience. The clinical preceptor will evaluate the student's performance and provide feedback on a regular basis. 5. Students will be evaluated upon the completion of each rotation" semester" to ensure that educational objectives are being met and student is eligible to pass this semester and move to the next one. 6. Assessment of the clinical training is represented in continuous assessment "Clinical Portfolio" and Performance assessment "OSCE for core courses" and is the responsibility of module coordinator. 7. Clinical Portfolio is an integral part the student assessment, it is supervised and evaluated by clinical preceptors. 8. Clinical Portfolio includes the following tools of evaluation: Personal developmental plan, DOPS, Mini-CEX, Evidence based assignments, Case based discussion, and Reflection.
Procedure	**Procedure steps** | **Responsibility**

	1. Module coordinator receive information about the rules for progression in the clinical training.	**MBBS Program Director**
	2. The evaluation criteria are disclosed to the students during the College orientation including the goals and objective of the program, assessment tools, assessment plan and grading.	**Module coordinator**
	3. Each student receives a portfolio including all evaluation tools at the beginning of each module.	**Module coordinator**
	4. Each group of students will be assigned to a clinical preceptor.	**MBBS Program Director**
	5. Follow up of students' professional behavior and clinical performance are monitored on a weekly basis by discussing personal developmental plans and reflection.	**HOD**
	6. The clinical preceptors are responsible for informing students that are not adherent to the clinical training schedule regarding their areas for improvement.	**Clinical preceptor**
	7. The clinical preceptors are responsible for informing the module coordinator about the students that are not compliant with the schedule. Accordingly, these cases will be discussed in assessment subcommittee and decision will be taken.	**Clinical preceptor**
	8. During the clinical training, the clinical preceptor and module coordinator should provide the students with approved formative and summative evaluation.	**Clinical preceptor** **Module coordinator**
	9. The clinical preceptor is responsible to conduct the following according to the assessment plan (attachment 1) 9.1. Direct Observation of Procedural Skills (DOPS). 9.2. Mini Clinical Evaluation Exercice (Mini-CEX). 9.3. Case Based Discussions. 9.4. Evidence based assignment.	**Clinical preceptor**

	10. The clinical preceptor is responsible to rate the student's performance using the approved checklists.	**Clinical preceptor**
	11. Students must receive constructive and timely feedback about their assessment tasks.	**Program Director** **Module coordinator**
	12. The clinical preceptor will provide a final evaluation at the end of the module by using In-Training Evaluation Report **(Attachment 2).**	**Clinical preceptor**
	13. Assessment methods are aligned with clinical training competencies.	**MBBS Program Director**
	14. Assessment procedures are adhered to clinical training competencies.	**MBBS Program Director**
	15. Marks will be allocated according to the assessment plan of each module.	**Module coordinator**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-18	
Policy Title: Clinical Training Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 11-8-2021	
	Version-2 is Approved on: 10-8-2024	
Applicable to: MBBS Program	To be Reviewed on: 10-8-2029	

Statement of the Purpose	To provide guidance about students' supervision, training and evaluation to clinical instructors/consultants and clinical preceptors responsible for MBBS students clinical training at different clinical training placements.
Policy	1. The Clinical Training Policy provides structured framework and clear guidelines for clinical teaching, training and supervision in undergraduate MBBS program in order to ensure effective and consistent teaching and training occurs across MBBS Program. 2. The policy framework ensures that clinical teaching and training activity are at a level that ensures future students' competences and skills. 3. The policy is developed to ensure teaching and training structures and systems are maintained across all MBBS program years.

Procedure

Procedure Steps	Responsibilities
1. Clinical preceptors and students must be prepared to show evidence that they have met college and clinical placement requirements. Students are required to complete (Undergraduate Student-Medical Checkup and Vaccination Form), BLS certificate and orientation checklist form prior to enrolling in clinical courses (refer to Students Eligibility & Requirements policy).	**Clinical preceptors and students**
2. FCMS conducts orientation program for faculty and clinical preceptors' prior students' entrance to clinical placements about module learning outcomes, clinical portfolio tasks, assessing and supervising students in clinical placement.	**MBBS Program director**
3. Orientation program is conducted to students including compliance to all hospital policies and procedures, code of conduct and clinical portfolio tasks and learning	**MBBS Program director**

	objectives of their current clinical assignments, in addition to that, clerkship guide is provided to students before clerkship years **(attachment 1)**.	
	4. Hospital orientation is conducted for students with respect to the physical facilities, policies, and procedures of the clinical placement sites.	**Clinical preceptors** **College clinical coordinator**
	5. The clinical placements are regularly audited by a team from the college side yearly. Each placement is approved as being a suitable learning unit for students to meet the required clinical course objectives (refer to Clinical Training Facility Selection Policy).	**College clinical coordinator** **Clinical Sciences Department**
	6. The students who are going to attend the clinical training are identified and a list for each year is prepared.	**College clinical coordinator** **Clinical Sciences Department**
	7. Students' lists will be forwarded to the VDCA of FCMS who will coordinate with the chair of clinical departments at DSFH.	**College clinical coordinator** **Clinical Sciences Department**
	8. Approved clinical training schedules (timetables) will be announced to students including: 8.1. bedside teaching 8.2. clinics. 8.3. other clinical placements. 8.4. Shadowing.	**College clinical coordinator** **Clinical Sciences Department**
	9. Module coordinator provides the following documents to the clinical placement at the beginning of each semester: Course number and title, Course objectives and clinical training plan ,Student's clinical rotation plan and number of students in each group and module coordinators names with contact numbers	**College clinical coordinator**
	10. Clinical placement sites provide opportunities for observation and practical experience, and to meet the stated learning objectives.	**College clinical coordinator** Clinical Training Unit MBBS Program Director

	11. Unsatisfactory clinical performance and unsafe behavior by students will be met by immediate preceptor intervention to protect patients and others. Examples of unsafe behaviors include: Performing any procedure without direct faculty supervision after specific instruction by the clinical faculty member.	**Clinical preceptors**
	12. Each student enrolled in a clinical course in the college will receive a portfolio specific for each module. Students will be responsible for following all guidelines stated in the portfolio.	**MBBS Program director**
	13. During the clinical training, clinical preceptor is responsible to teach students clinical skills and reasoning.	**Clinical preceptors**
	14. The Clinical preceptor continuously supervises students' clinical performance during clinical rounds.	**Clinical preceptors**
	15. The clinical preceptor acts as role model to nurture professional behavior among students.	**Clinical preceptors**
	16. The college clinical coordinator will monitor students in clinical experiences in each module using the approved checklist.	**College clinical coordinator**
	17. Faculty members and hospital staff are responsible for students at the clinical settings to protect them from unnecessary exposure to dangerous situations	**Clinical preceptors**
	18. Clinical preceptors/ consultants are responsible for the students' performance, supervision, and evaluation during their rotation.	**Clinical preceptors**
	19. Students are expected to maintain a professional appearance in relation to clothing, hair, nails, shoes, and communication. Students' appearance should not risk, offending or disturbing patients.	**Students**

	20. Clinical Placement Evaluation should be done at the end of each semester by students, analysis of the evaluation is carried out by the college Quality and Accreditation Unit and the module coordinator will include the result in the course report.	**Students** **QAU**
	21. The clinical teaching and training in MBBS program begin as early as second year where all the students go through Observership program. (refer to observership policy).	**Clinical preceptors**
	22. Clinical teaching and training in MBBS program are designed and structured as follows: 22.1. Second year students. (refer to observership policy) 22.2. Third Year students	**Clinical preceptors**
	22.2.a. The clinical preceptors train students in history taking and clinical examinations in Clinical skills laboratory.	**Clinical preceptors**
	22.2.b. The module coordinator assigns the students to clinical rotations in relevant different specialties.	**College clinical coordinator**
	22.2.c. The students receive their clinical portfolio for each specialty before hospital clinical rotation.	**Module coordinator** **MBBS Program director**
	22.2.d. The students are supervised by the clinical preceptors/consultants.	**Clinical preceptors**
	22.2.e. The students rotate in different parts in assigned specialty (outpatient clinics, inpatient, operating rooms and emergency department).	**Students**
	22.2.f. The students observe the clinical preceptors/consultants' communication with patient during history taking and examination.	**Clinical preceptors**
	22.2.g. In each of these rotations the students record the observed cases and the accompanied consultant sign students' portfolio for that.	**Students**

	22.2.h. The students are requested to take history from patients and participate in clinical examination with the consultant.	**Students**
	22.2.i. The consultant assesses students' behaviors and code of conduct according to the checklist in clinical portfolio.	**Clinical preceptors**
	22.2.j. The students are requested to take complete history and write a report.	**Students**
	22.2.k. Students are assigned to clinical preceptor where debriefing sessions are conducted with students for Case based Discussion.	**Students**
	22.2.l. The students are assessed according to the Case-based Discussion rubric.	**Students**
	22.2.m. At the end of rotation, the students are requested to choose one critical incident, he\she faced at the clinical experience of the module and reflect upon the incident.	**Students**
	22.3. In clerkship phase, clinical teaching and Training are conducted as follows:	
	22.3.a. Students receive clerkship guides that include all clinical learning outcomes expected from them during clerkship years.	**Module coordinator** **MBBS Program director**
	22.3.b. Students receive their clinical portfolio at the beginning of their modules with the required clinical tasks.	**MBBS Program director**
	22.3.c. Entrustable Professional activities (EPAs) are requested from students to achieve during the clerkship.	**Students**
	22.3.d. Clinical teaching and training sessions are categorized as follows: 22.3.d.1. Standardized patient sessions: (refer to standardized patient policy) 22.3.d.2. Bedside teaching clinical session, in this session the following is done:	
	Preparation and planning	
	22.3.d.2.1. The clinical preceptor/consultant recognizes the learning outcomes of the session according to the planned curriculum.	**Clinical preceptors**
	22.3.d.2.2. The clinical preceptor/consultant plans for the sessions carefully and	**Clinical preceptors**

	identify patient appropriate for achieving learning outcomes of the session	
	22.3.d.2.3. The clinical preceptor/ consultant approaches the patient beforehand and explains to the patient that a group of students will see him/her.	**Clinical preceptors**
	22.3.d.2.4. The clinical preceptor/consultant gives details to the patient about how long the session is likely to take and agree upon that the patient can give if he/she wishes to end the session.	**Clinical preceptors**
	Implementation phase	
	22.3.d.2.5. The clinical preceptor/consultant monitors students' attendance and dress code in their clinical portfolio.	**Clinical preceptors**
	22.3.d.2.6. The clinical preceptor/consultant identifies one student to take history from the patient.	**Clinical preceptors**
	22.3.d.2.7. The clinical preceptor/consultant makes students actively participate in rounds through asking questions.	**Clinical preceptors**
	22.3.d.2.8. The clinical preceptor/ consultant helps students to have information about the identified patients immediately available (e.g., vital signs, laboratory data, diagnostic studies, medications) from shadow file.	**Clinical preceptors**
	22.3.d.2.9. The clinical preceptor/consultant conducts debriefing session with students to discuss the examined cases to improve clinical reasoning and critical thinking.	**Clinical preceptors**
	22.3.d.2.10. The clinical preceptor/ consultant gives students feedback about their performance in bed side teaching.	**Clinical preceptors**

	22.3.d.2.11. The clinical preceptor/ consultant teaching skills will be evaluated by students (attachment 3).	**Clinical preceptors**
	22.3.d.3. Clinical teaching and training session in simulation center using medium and high-fidelity mannequins and part-task trainers.	**Clinical preceptors**
	22.3.d.4. Visits to community medicine sites like (Primary health care, public health Management, occupational sites, and environmental sites).	**Students**
	22.3.d.5. Using the shadow file in clinical teaching and assessment sessions.	**Students**
	22.4. At the end of the module, the coordinators write the course report at the end of each semester, report is reviewed and signed by program director and finally is submitted to the Medical Education Department and QAU.	**Coordinator**
	23. Course reports should be archived each year by the module coordinator, with copies kept in the college QAU.	**College clinical coordinator**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-19	
Policy Title: Utilization of Shadow file	☐ New	☑ Revised
	Version-1 was Prepared on: 12-8-2021	
	Version-2 is Approved on: 10-8-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 10-8-2029	

Statement of the Purpose	1. To set out the rules and regulations governing the use of Shadow file. 2. To identify the individuals who should have access to review and/or enter information in the shadow file. 3. To establish a monitoring process for accessing and utilization of the shadow file.
Policy	1. To ensure that the students and clinical staff have access to shadow file and can browse and enter information successfully. 2. To guarantee that the students will not use the DSFH live Yasassi. 3. To ensure the confidentiality of the of patient information by accessing medical records of patients without personal identification. 4. To ensure the satisfaction of the students with using the shadow files.

Procedure

Procedure steps	Responsibility
1. IT department at DSFH will use the live Yasashi to install a copy from the patients' medical records in a separate server.	**IT Department at DSFH** **IT Unit at FCMS** **Program director** **Medical students** **Vice Dean of Clinical Affairs** **Clinical staff members**
2. This copied version will be named "Shadow file".	**IT Department at DSFH**
3. After installation of the shadow file by IT department at DSFH, they will give access to the IT unit at FCMS to start installation of the shadow file server at the College computers/tablets.	**IT Department at DSFH** **IT Unit at FCMS**
4. After installation of the shadow file at the college, IT unit at FCMS will give access to students and clinical staff members by creating usernames and passwords for the users.	**IT Unit at FCMS**

	5. The IT unit at FCMS will ensure that up to 100 concurrent users can access the shadow files.	**IT Unit at FCMS**
	6. Training of the IT unit at the FCMS for using the shadow file will be done by IT department at DSFH.	**IT Department at DSFH** **IT Unit at FCMS**
	7. Training of the students will be done by the IT Unit at FCMS.	**IT Unit at FCMS** **Students** **Program director** **Vice Dean of Clinical Affairs** **Clinical staff members**
	8. The students can access the shadow file at DSFH and the College computers.	**IT Unit at FCMS** **Students**
	9. The students should access the shadow file and do the following:	**Students** **IT Unit at FCMS**
	9.1. **Browse the Patient Medical Record**	
	9.1.1. Access electronic medical records of patients without personal identification and can access the following information: • Outpatient Department (OPD) assessment Form • ER admissions • Inpatient admission • Progress notes • Re plan to consultation • Referral/handover 9.1.2. Review clinical reports data • Vital data • Radiology • Medication	**Students** **IT Unit at FCMS**
	9.2. **Enter information:**	
	• Write medical notes (History/findings of the examination/Differential diagnosis) • Write the required investigation • Write management plan	**Students** **IT Unit at FCMS**
	10. Monitoring the use of shadow file:	**Clinical staff members** **Program director** **Vice Dean of Clinical Affairs**

	10.1. The IT of FCMS will check the utilization of shadow files.	**IT Unit at FCMS**
	10.2. The students' satisfaction about the use of shadow file will be evaluated.	**Clinical staff members** **Program director** **Vice Dean of Clinical Affairs**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-20	
Policy Title: Internship Eligibility and Requirements Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 12-6-2023	
	Version-2 is Approved on: 13-6-2023	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 13-6-2028	

Statement of the Purpose	1. To identify eligible candidates for the internship program. 2. To set the requirements for screening students for the internship program. 3. To identify the rules and regulations of eligibility and requirements for the internship program.
Policy	1. This policy and its associated framework are applied to the MBBS internship program at FCMS with the aim of identifying the eligibility and requirements of medical students before joining the internship program.

Procedure

Procedure steps	Responsibility
The candidate applying for the internship program must fulfill the following requirements: 1. Complete all academic requirements and obtain 215 credit hours composed of theory, skills laboratory, and clinical practice under the MBBS Program. 2. Have a Cumulative Grade Point Average (GPA) of not less than 3. Be Certified as Basic Life Support (BLS) provider. 4. Obtain a medical clearance from the DSFH staff clinic physician or from any other authorized agency. (see Annex 5.1)	**Program Director Registration unit**
5. Students applying for the internship year must comply with the specified immunizations, otherwise they may not be allowed to participate in any clinical exposure until immunization records are completed and submitted. They are: • Mendel-Mantoux Test/Purified Protein Derivative • Measles, Mumps and Rubella (MMR) Vaccine • Varicella Vaccine • Hepatitis B Titer and Immunization And complete the following tests:	**Internship unit. Registration unit**

	• Hepatitis C Test • Human Immunodeficiency Virus (HIV) Test	
	6. If the student intern is pregnant, she must apply and pre-arrange the request for postponing with the college internship coordinator and must be approved by the MBBS Program Steering Committee (MPSC) after discussion in Internship and Clinical Training Committee.	**Intern** **MPSC** **Internship and clinical training committee** **Vice Dean for Clinical Affairs**
	7. If the student intern is exposed to body fluids and needle prick incident, he/she must follow hospital policy on reporting the event and procedures. Incident report must be submitted to the risk management unit and a copy to be submitted to the college internship coordinator.	**Internship unit** **College Internship coordinator**
	8. Must attend the following orientation: a. Dr. Soliman Fakeeh Hospital (DSFH). b. Fakeeh College for Medical Sciences. c. Other required distant site placements.	**Internship Unit** **College Internship coordinator**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-21	
Policy Title: Research Project Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 6-10-2020	
	Version-2 is Approved on: 29-9-2022	
Applicable to: MBBS Program	To be Reviewed on: 29-9-2027	

Statement of the Purpose	To assist and provide guidelines for MBBS students and their supervisor(s) at Fakeeh College for Medical Sciences (FCMS), in preparing and completing efficiently their research project and aid in solving problems that may arise.
Policy	1. This policy is to provide guidelines for MBBS Students at FCMS to follow regulations of FCMS in the approval for the research project topics, writing the research project to fulfill the requirements of MBBS program graduation. 2. RP contributes to the achievement of SaudiMed competencies (Research and scholarship). Students must choose a research question that is based on an area of interest to them and according to MBBS program research priorities. They explore and develop one or more capabilities in the context of their research. The RP provides a valuable opportunity for FCMS students to develop and demonstrate competencies and skills essential for conducting research. It enables students to develop vital skills of planning, research, synthesis, evaluation, and project management. 3. The MBBS Program Director in collaboration with P-SRC assign supervisor(s) according to FCMS regulation. 4. Supervisor whether (Professor, Associate Professor or Assistant Professor- with at least two years after getting the PhD degree or its equivalent and has at least two research publications. 5. The supervisor can supervise up to three groups of students, at one time, in case of extreme necessity and according to MBBS Program Scientific Research Committee (P- SRC) recommendation and the approval of CC and can be increased to four. 6. In case the supervisor(s) cannot continue the supervision or completion of services at the college, P-SRC recommends a substitute supervisor (s) and to be approved by the CC. 7. Supervisors must submit a detailed report about students' progress to the Program Director and P-SRC at least once per semester.
Procedure	The procedure and framework of RP includes three phases as explained in the table below: **First phase:** Planning, registration, and proposal approval.

Second Phase: Developing and conducting research.
Third phase: Reporting, review and assessment.

The table below describes the students and supervisors on activities occurring in each phase in relation to SaudiMed competences, in addition to that it identifies the timeline for each phase and students' output.

Phase	No. weeks	Milestones of research and scholar competence of Saudi Med	Students' activities	Supervisors' activities	Students' output
Phase 1: Planning, registration and approval	3-6 months (12-24 hours)	• Demonstrate ethical and governance issues related to medical research. • Appraise critically the available research evidence to address issues related to medical practice. • Apply the principles of research methodology. • Develop research proposal.	• Identify the research topic after brainstorming sessions between students. • Prepare a plan and focus on issues and ideas in their area of interest. • Formulate clearly the statement of research problem. • Consult supervisor and others with expertise in their area of interest. • Select, cite and synthesize properly related literature. • Use references according to ethical standards. • Describe adequate research design. • Review and modify the research according to the feedback received from the supervisor. • Create research proposal.	• Monitor and direct the students' work. • Gives guidance about relevant literature on topic under studying appropriate literature sources. • Assist in identification of appropriate research methodology. • Revise the final research proposal and discuss it with students. Progress report.	• Topic choice. • Research project proposal (using the IRB template) including literature review and research methodology. • Conceptual framework.
Phase 2: Developing and conducting research	6-12 months (24 -48 hours)	• Apply the principles of research methodology, data collection and appropriate statistical techniques.	• Apply safe and ethical research processes. • Collect and analyze data. • Participate in discussions with the supervisor about the progress of their research. • Review and modify the research according to the feedback received from the supervisor.	• Assist in identification of appropriate research methodology, planning and executing of research project. • Give feedback on progress achieved by students. • Revise students' work.	• Data collection tools. • Data analysis. •

				• Maintain a record of progress made and sources used. • Synthesis of knowledge, skills, and ideas to produce a resolution to the research question.	• Progress report.	
Phase 3: Reporting, review and assessment	6-12 month (24 -48 hours)	• Demonstrate the ability to write a manuscript according to publication standards. • Demonstrate and appreciate the role of peer assessment.	• Organize their information coherently and communicate ideas accurately and appropriately. • Review the knowledge and skills developed in response to the research question (s) (e.g. what they have learnt about their research, what practical and theoretical skills they have developed through their research). • Communicate in written, oral, or multimodal form. • Evaluate their peers fairly. • Finish their research project by finalizing their manuscript. • Publishing their research manuscript.	• Give feedback on progress achieved by students. • Revise students' work. • Give guidance about research RP writing. • Assess each student's performance and work in developing and conducting RP. • Help students to publish their RP. • Assessment rubric of research project outcome.	• Assessment rubric of research proposal. • Assessment rubric for RP. • Peer Evaluation of Research Project. • Progress report. • Research project presentation/ poster presentation publication/ manuscript.

Procedure steps	Responsibility
1. **Research project registration and approval**	
1.1. A student will be eligible to enroll for a research project after successfully completing the principle of research course (MED 211). This means that the MBBS student will be in the first semester of third year.	**Program Director and P-SRC**
1.2. The program director with collaboration of chairperson of the MBBS Program Scientific Research Committee (P-SRC) divide the students into RGs.	**Program Director and P-SRC**
1.3. Program director in collaboration with chairperson of the MBBS Program Scientific	**Program Director and P-SRC**

	Research Committee (P-SRC) assign the supervisor (s) for each group of students. RGs then be approved by MBBS Steering Committee (MPSC)	
1.4.	The selection of research project topic by the RGs will be made according to the area of research interest within the field of medicine and the identified MBBS program research priorities, with the help of the supervisor.	**RG Supervisor and students**
1.5.	The RGs choose a title for their RP assisted by their supervisor(s).	**RG Supervisor and students**
1.6.	Each student should participate in developing research project proposal.	**RG Supervisor and students**
1.7.	All students should be aware of all parts of the research proposal and share the responsibilities of doing it.	**RG Supervisor and students**
1.8.	The RGs write the RP proposal as a group work of 4 to 6 students maximum, students work under the guidance of their supervisor (s).	**RG Supervisor and students**
1.9.	The supervisor submits the proposal to the chairperson of P-SRC.	**RG Supervisor**
1.10.	Proposal contents and structures will be reviewed by the P-SRC members using reviewing checklist.	**P-SRC members**
1.11.	The Proposal will be sent to the SRU for submission to Institutional Review Board (IRB)	**Chairperson of P-SRC and Manager of SRU**
1.12.	Once approved by SRU, the next step is to get the IRB ethical approval.	**SRU**
1.13.	If the proposal is approved by the IRB committee, main researcher will receive the ethical approval via email through the IRB research coordinator office.	**IRB research coordinator**
1.14.	Official letters will be provided to students from Deanship office according to student's request to assist for getting permission of data collection from designated institution.	**Students and Dean**
2.	**Developing and conducting research phase**	
2.1.	The research process is done under the guidance of the supervisor (s), there should be satisfactory means of communication between student and the supervisor(s), the RGs need to be in regular contact with the	**RG Supervisor and students**

	supervisor(s) to provide progress and guidance as needed.	
2.2.	Supervisor(s) guide students, to adhere to the requirements outlined in the student's research project writing manual (Appendix II).	**RG Supervisor**
2.3.	RGs share the responsibilities of conducting the research project and distributing the tasks between them with the guidance of the supervisor.	**RG Supervisor and students**
2.4.	Students will share draft work of research project with the supervisor(s) regularly and have feedback to ensure that the work is on track.	**RG Supervisor and students**
2.5.	Supervisor(s) and the students must submit a written summary of the progress to the MBBS program director and chairperson of MBBS P-SRC at least once per semester and outline any difficulties faced (Appendix III).	**RG Supervisor and students**
2.6.	Students have to spend from 1-3 years for the research project work according to the type of research.	**RG Supervisor and students**
2.7.	Students develop literate for the selected RP to identify the gap in research.	**RG Supervisor and students**
2.8.	The students use valid sources according to ethical standards, follow adequately their research design, collect and analyze data.	**RG Supervisor and students**
2.9.	The students apply safe and ethical research processes.	**RG Supervisor and students**
2.10.	The students review and modify the research according to the feedback received form the supervisor.	**RG Supervisor and students**
2.11.	The students maintain a record of progress made and sources used.	**RG Supervisor and students**
2.12.	For non-compliant students, a meeting will be conducted with these students and their supervisor with the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR) to discuss their struggles and to receive a verbal warning and to get a second chance of proposal submission. If the students still didn't submit the proposal, a first warning letter will be issued. A second warning letter	**RG Supervisor** **Program Director** **P-SRC** **Manager of SRU** **VDPGSSR**

	may be issued if necessary. Students will be eligible for dismissal if they showed unresponsive actions based on their research supervisor report, program director, and P-SRC (Annex IV).	
2.13.	The students should reach and meet all their research objectives and answer their research questions at the end of their RP.	**RG Supervisor and students**
2.14.	Follow up of students and their progress will be discussed in every departmental council of clinical sciences as a fixed agenda. A meeting to be held with the supervisor(s), program director and chairperson of SRC, twice during the semester to oversee the progress and to support the students.	**Program Director**
3.	**Reporting, Review and assessment phase**	
3.1.	Students organize their information coherently and communicate ideas accurately and appropriately in written and/or oral form.	**RG Supervisor and students**
3.2.	The supervisor(s) inform the program director and P-SRC that the students' work is completed and published.	**RG Supervisor**
3.3.	In the final level, last semester of sixth year, the students will have a research project course, in which the RP will be assessed. The assessment of RP has two components as follows: 3.3.1. Internal assessment within FCMS (70%) distributed as follows: a. Research project proposal assessment by rubric (By Research Project course coordinator and Program Director to assign faculty staff for each student proposal): (10%) (Annex I). b. Research Outcome Assessment by rubric (by the supervisor): (20%) (Annex V) In case the supervisor of the RP was replaced, the Research Outcome Assessment of the	**RG Supervisor** **Research Project course instructors** **Program Director** **Supervisor** **Students and peers in the same group** **Research Project course instructors** **Research Project course instructors**

	students will be average of the evaluation of all supervisors. c. Peer Evaluation of Research Project by rubric (students and peers in the same group) (5%) (Annex VI) d. Presentation/ Poster of the Research Projects by rubric: (15%) (Annex VI) e. Workshops attendance and participation according to the assigned topic (Assignment evaluation using rubric) (20%) (Annex VI) 3.3.2. External Assessment (30%) The students deserve the full mark (30) of external assessment if the research article is published in indexed peer reviewed journal. If not, and the students have other published research rather than FCMS research project, students will deserve 20 out of 30. If the students do not have any publication, the research project manuscripts will be assessed internally by faculty members and the manuscript will be evaluated from 10 not 30 (Annex VII)	
	3.4. If a student cannot successfully pass the research project course (less than 60 out of 100), the students must have resit. The resit of the research project course will be out of 100 as follow: a. The students must submit proposal modified according to rubric, which will be evaluated out of 25. b. The students must prepare and display a presentation of the research project, which will be evaluated out of 25. c. The students must submit manuscript modified according to rubric, which will be evaluated out of 25.	**Students and Research Project course Coordinator**

		d. The students must perform activities related to the workshops, which will be evaluated out of 25.	
	3.5.	The report is discussed then in MPSC then is submitted to Institutional Curriculum Monitoring and Reviewing Committee (ICRMC).	**HOD**
	3.6.	Completing the RP is mandatory for students to be eligible for graduation.	**HOD**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-22	
Policy Title: Clinical Training in Distant Clinical Placements Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 19-1-2022	
	Version-2 is Approved on: 19-1-2025	
Applicable to: MBBS Program	To be Reviewed on: 19-1-2029	

Statement of the Purpose	To provide guidance about students' supervision, training, and evaluation to consultants responsible for MBBS students clinical training at distant clinical training placements outside FCMS campus.
Policy	1. The Clinical Training in Distant Clinical Placement Policy provides structured framework and clear guidelines for clinical teaching, training, supervision and assessment in undergraduate MBBS program in order to ensure effective and consistent teaching and training occurs across MBBS Program.

Procedure

Procedure Steps	Responsibilities
1. Clinical preceptors and students must be prepared to show evidence that they have met college and clinical placement requirements. Students are required to complete (Undergraduate Student-Medical Checkup and Vaccination Form, BLS certificate and orientation checklist form prior to enrolling in clinical courses (refer to Students Eligibility & Requirements policy).**(attachment 1)**	**Students**
2. FCMS conducts orientation program for consultant prior students' entrance to clinical placements about the module intended learning outcomes, students' schedule, clinical portfolio tasks, assessing and supervising students in clinical placement.	**Hospital Clinical Training Coordinator**
3. Module coordinator provides the following documents to the clinical placement at the beginning of each semester: Course number and title, Course objectives and clinical training plan, Student's clinical rotation plan and number of students in each group as well as their names with contact numbers.	**College Clinical Training Coordinator**

	4. Orientation program is conducted to students including compliance to all hospital policies and procedures, code of conduct and clinical portfolio tasks and learning outcomes of their current clinical assignments.	**Hospital Clinical Training Coordinator**
	5. Hospital orientation is conducted for students with respect to the physical facilities, policies, and procedures of the clinical placement sites.	**Hospital Clinical Training Coordinator**
	6. The clinical placements are regularly audited by a team from the College side annually. Each placement is approved as being a suitable learning unit for students to meet the required clinical course objectives (refer to Clinical Training Facility Selection Policy).	**MBBS Program Director** **College Clinical Training Coordinator** **Hospital Clinical Training Coordinator**
	7. The students who are going to attend the clinical training are identified and a list for each year is prepared.	**MBBS Program Director**
	8. The MBBS program director will prepare students' lists and schedules that will be forwarded to the Vice Dean for Clinical Affairs (VDCA) and Vice Dean for Academic Affairs (VDAA) of FCMS who will coordinate with the Hospital Clinical Coordinator at distant clinical placements outside FCMS.	**MBBS Program Director**
	9. Approved clinical training schedules (timetables) will be announced to students.	**Hospital Clinical Training Coordinator**
	10. Distant clinical placement sites provide opportunities for observation and practical experience and to meet the stated learning objectives.	
	11. Unsatisfactory clinical performance and unsafe behavior by students are requiring immediate consultant intervention to protect patients and others. Examples of unsafe behaviors include: Performing any procedure without direct consultant supervision after specific instruction by the consultant.	**Hospital Clinical Training Coordinator**

	12. Each student enrolled in a clinical course in the college will receive a portfolio specific for each module. Students will be responsible for following all guidelines stated in the portfolio	**Hospital Clinical Training Coordinator**
	13. During the clinical training, consultants are responsible to teach students clinical skills and reasoning	**Clinical consultants**
	14. The consultant continuously supervises students' clinical performance during clinical rounds.	**Clinical consultants**
	15. The consultant acts as role model to nurture professional behavior among students.	**Clinical consultants**
	16. The College clinical training coordinator will monitor students in clinical experiences in each module using the approved checklist.	**Clinical training coordinator**
	17. The consultants are responsible for students at the clinical settings to protect them from unnecessary exposure to dangerous situations.	**Clinical consultants**
	18. The consultants are responsible for the students' performance, supervision, and evaluation during their rotation.	**Clinical consultants**
	19. Students are expected to maintain a professional appearance related to clothing, hair, nails, shoes and communication. Students' appearance should not risk, offending or disturbing patients.	**Students**
	20. In clerkship phase, clinical teaching and training in distant sites are conducted as follows:	
	20.1.a. Students receive clerkship guides including all clinical learning outcomes expected from them during clerkship years.	**Clinical training coordinator**
	20.1.b. Students receives their clinical portfolio at the beginning of their modules with the required clinical tasks.	**Clinical training coordinator**
	20.1.c. In Bedside teaching clinical session, the following is done:	**Clinical consultants**
	Preparation and planning	
	20.1.c.1. The consultant recognizes the learning outcomes of the session according to the planned curriculum.	**Clinical consultants**

	20.1.c.2. The consultant plans for the sessions carefully and identify patient appropriate for achieving learning outcomes of the session.	**Clinical consultants**
	20.1.c.3. The consultant approaches the patient beforehand and explains to the patient that a group of students will see him/her.	**Clinical consultants**
	20.1.c.4. The consultant gives details to the patient about how long the session is likely to take and agree a signal that the patient can give if he/she wishes to end the session.	**Clinical consultants**
	Implementation phase:	
	20.1.c.5. The consultant monitors students' attendance and dress code in their clinical portfolio.	**Clinical consultants**
	20.1.c.6. The consultant identifies one student to take history from the patient.	**Clinical consultants**
	20.1.c.7. The consultant makes students actively participate in rounds through asking questions.	**Clinical consultants**
	20.1.c.8. The consultant helps students to have information about the identified patients immediately available (e.g., vital signs, laboratory data, diagnostic studies, medications) from shadow file.	**Clinical consultants**
	20.1.c.9. The consultant conducts debriefing session with students to discuss the examined cases to improve clinical reasoning and critical thinking.	**Clinical consultants**
	20.1.c.10. The consultant gives students feedback about their performance in bedside teaching.	**Clinical consultants**
	20.1.c.11. The consultant teaching skills will be evaluated by students**.**	**Clinical consultants**
	21. **Student assessment at distant clinical placements:**	
	21.1.a. Each consultant is assigned for a number of students (5-6 students) to evaluate their performance and ensure individualized feedback and training.	**Clinical consultants**
	21.1.b. Follow up of students' professional behavior and clinical performance are monitored on a weekly basis by discussing personal developmental plans and reflection.	

	21.1.c. The consultants are responsible for informing students that are not adherent to the clinical training schedule regarding their areas for improvement.	**Clinical consultants**
	21.1.d. The consultant is responsible to conduct the following according to the assessment plan:	**Clinical consultants**
	• Direct Observation of Procedural Skills (DOPS).	
	• Mini Clinical Evaluation Exercice (Mini-CEX).	
	• Case Based Discussions.	
	• Evidence based assignment.	
	21.1.e. The consultant is responsible to rate the student's performance using the approved checklists.	**Clinical consultants**
	21.1.f. The consultants will provide a final evaluation at the end of the module by using In-Training Evaluation Report.	**Clinical consultants**
	22. **Monitoring the clinical training in distant sites:**	**MBBS Program Director College Clinical Training Coordinator Hospital Clinical Training Coordinator**
	22.1.a. The College clinical training coordinator will monitor students in clinical training placement on daily bases using the approved checklist.	**Clinical training coordinator**
	22.1.b. The Program Directors conduct weekly meetings with the VDAA, Head of Clinical Sciences Department, year coordinator, module coordinator to discuss the conduction clinical training and overcome any obstacles or challenges as early as possible.	**MBBS Program Director**
	22.1.c. Monitoring the implementation of clinical training on monthly bases in MBBS Program-Internship and Clinical Training Subcommittee that will report to the MBBS Program Steering Committee.	**Program-Internship and Clinical Training Subcommittee**
	22.1.d. The internship and student training unit is responsible for monitoring the implementation	**The internship and student training unit**

	of training activities in the distant sites. It follows up with students and provides the necessary support during training periods. In addition, it ensures formal evaluation for each student prior to clinical rotation completion.	
	22.1.e. The IQAS is responsible for ensuring compliance with policies and procedure of the clinical training.	**IQAS**
	22.1.f. Clinical Placement Evaluation should be done at the end of each semester by students, analysis of the evaluation is carried out by the college Quality and Accreditation Unit and the module coordinator will include the result in the course report.	**Quality and Accreditation Unit**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-23	
Policy Title: Students Eligibility and Requirements Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 11-8-2021	
	Version-2 is Approved on: 10-8-2024	
Applicable to: MBBS Program	**To be Reviewed on: 10-8-2029**	

Statement of the Purpose	1. To set the demands for screening students before the clinical phase of MBBS program. 2. To identify the requirements of eligibility for the clinical phase of MBBS program.
Policy	1. The students of the MBBS program in FCMS must fulfill all requirements of eligibility before their entry into the clinical phase. 2. Requirements for eligibility includes students' compliance to specified immunizations, medical tests and attendance of specific orientation programs. 3. Students should submit their medical clearness for Admission Unit and Clinical Training Unit.

Procedure

Procedure Steps	Responsibilities
1. Obtain a signed medical clearance from the DSFH staff clinic doctor.	**Students** **Vice Dean for Clinical Affairs** **MBBS Program Director**
1.1. Students must comply with the specified serology testing and immunizations, otherwise they may not be allowed to participate in any clinical exposure until immunization records are completed and submitted. The following are mandatory testing: • Blood Group • Tuberculin Purified Protein Derivative (PPD) or QuantiFERON-TB Gold (QFT). • Measles, Mumps and Rubella (MMR)Ab-IgG. • Varicella Ab-IgG. • HBsAg (Hepatitis B Surface Ag) • Anti-HBs (Hepatitis B Surface Antibody)	**Students** **Vice Dean for Clinical Affairs** **MBBS Program Director**

	• Hepatitis C virus Antibody. • Human Immunodeficiency Virus (HIV) Test. 1.2. Immunization requirements will be determined based on serology results. **Mandatory Immunization:** • Meningococcal Conjugated Vaccine (Menactra) • Inactivated Influenza Vaccine	
	2. Attend the following orientation programs from the following: 2.1. Dr. Soliman Fakeeh Hospital (DSFH). 2.2. Fakeeh College for Medical Sciences.	**Students** **Vice Dean for Clinical Affairs** **MBBS Program Director**
	3. **Time Due** Must be accomplished before the start of the scheduled Year.	**Students** **Vice Dean for Clinical Affairs** **MBBS Program Director**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-24	
Policy Title: Internship Eligibility and Requirements Policy	☑ New	☐ Revised
	Version-1 was Prepared on: 12-6-2023	
	Version-2 is Approved on: 13-6-2023	
Applicable to: MBBS Internship Year	**To be Reviewed on: 13-6-2028**	

Statement of the Purpose	1. To identify eligible candidates for the internship program. 2. To set the requirements for screening students for the internship program. 3. To identify the rules and regulations of eligibility and requirements for the internship program.
Policy	1. This policy and its associated framework are applied to the internship program in FCMS with the aim of identifying the eligibility and requirements of Medical students before entry into the internship program.

Procedure

Procedure steps	Responsibility
The candidate applying for the internship program must fulfill the following requirements: 1. Must complete all academic requirements and obtain 215 credit hours composed of theory, skills laboratory, and clinical practice under the MBBS Program. 2. Cumulative Grade Point Average (GPA) of not less than 2. 3. Certified as Basic Life Support (BLS) provider. 4. Obtain a Medical Checkup and vaccination Form from the DSFH staff clinic physician or from any other authorized agency. (see Annex 5.1)	**Program Director** **Registration unit**
5. Students applying for the internship year must comply with the specified immunizations, otherwise they may not be allowed to participate in any clinical exposure until immunization records are completed and submitted (see annex 5.2). The following are: • Mendel-Mantoux Test/Purified Protein Derivative • Measles, Mumps and Rubella (MMR) Vaccine • Varicella Vaccine	**Internship unit.** **Registration unit**

	• Hepatitis B Titer and Immunization And complete the following tests: • Hepatitis C Test • Human Immunodeficiency Virus (HIV) Test	
	6. If a student intern is pregnant, she must submit a formal request in advance to postpone her internship through the College Internship Coordinator. The request must be reviewed and recommended by the MBBS Program Internship and Clinical Training Committee, then approved by the Clinical Sciences Department Council and the MBBS Program Steering Committee. Final approval must be obtained from the Institutional Internship and Student Training Committee.	**Intern** **College Internship Coordinator** **Clinical Sciences Department Council** **Internship and clinical training committee** **Institutional Internship and Student Training Committee**
	7. If the student intern is exposed to body fluids and needle prick incident, he/she must follow hospital policy on reporting the event and procedures. Incident report must be submitted to the risk management unit and a copy to be submitted to the college internship coordinator.	**Internship unit** **College Internship coordinator**
	8. Must attend the following orientation: 8.1. Dr. Soliman Fakeeh Hospital (DSFH). 8.2. Fakeeh College for Medical Sciences. 8.3. Other required distant site placements.	**Internship Unit** **College Internship coordinator**
	9. Internship Unit and the Internship and clinical training Committee are the bodies which are responsible for identifying and verifying the students eligible for the internship program.	**Internship Unit** **Internship and Clinical Training committee**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-25	
Policy Title: Internship Program Orientation Policy	√ New	☐ Revised
	Version-1 was Prepared on: 18-6-2023	
	Version-1 is Approved on: 19-6-2023	
Applicable to: MBBS Program	To be Reviewed on: 19-6-2028	

Statement of the Purpose	1. To provide important information about internship year guidelines and policies and procedures of FCMS and DSFH. 2. To provide them with knowledge, skills and attitudes that prepare them for clinical practice during the internship year and beyond.
Policy	1. This policy provides clear guidance for medical interns about the orientation program. 2. The MBBS intern must attend one week orientation program offered at the college. 3. The MBBS intern must attend the orientation program in the hospital for one week. 4. The MBBS interns must participate in the activities during the orientation sessions and prepare themselves with required knowledge. 5. It is a mandatory requirement for the students to attend the orientation program to be eligible to enter the internship year-"No Orientation, No Internship Training". 6. The medical intern who is absent for more than 3 sessions in the orientation program will not be eligible to start the internship year. He/she will be asked to apply to the next batch of internship.
Procedure	

Procedure steps	Responsibility
Pre-orientation phase (Planning)	
1. Prepare the 'Field Experience Specification' and identify the learning outcomes, training strategies and assessment criteria before developing the orientation program.	**Internship unit (IU), Program director, Assessment unit and VDCA.**
2. Develop the orientation program (program schedule, program content, and participating staff) in collaboration with the college and hospital team members involved in the program.	**IU**

	3. A post-orientation evaluation plan must be formulated to assess the effectiveness of the program.	**IU**
	4. Materials for sessions and hands-on workshops must be prepared.	**IU & Involved Team members**
	5. Ensure that the students are registered in the internship year.	**IU Registration Unit**
	6. Make sure that the students fulfil all mandated requirements for enrolling into internship as per "Internship Eligibility and Requirements Policy."	**IU,Internship Coordinator, Program Director, clinical training committee, and VDCA**
	Orientation Phase (Implementation)	
	7. After fulfilling the eligibility requirements, the medical student must attend College and Hospital orientation programs which span for a period of 2 weeks including 8 workshops.	**IU,Internship Coordinator, clinical training committee, Program Director and VDCA**
	8. Students are given orientation about the internship year program, patient safety guidelines, hospital policies and procedures, internship policies and procedures, duties and responsibilities as an intern, expectations, support services, medical ethics, assessment methods and portfolios.	**IU, Internship Coordinator, clinical training committee, Program Director and VDCA**
	Post-orientation phase (Evaluation)	
	9. After successfully attending the College and hospital orientation program, all interns need to sit for a post-test and a 12-stations OSCE in which they must pass (minimum 60% score).	**Internship Coordinator, IU, Program Director and VDCA**
	10. After passing the post-test and OSCE, the interns can start training according to the rotation plan/placement.	**IU, Internship Coordinator, Program Director and VDCA**
	11. Evaluation of the orientation program is conducted through the satisfaction survey.	**Internship Coordinator & Quality and Accreditation Unit (QAU)**
	12. The effectiveness of the orientation program is monitored through the identified Key Performance Indicators (KPIs).	**IU & QAU**
	13. Area for improvement are identified and action plans are implemented for enhancement of the orientation program.	**IU & QAU**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-26	
Policy Title: Leave and Freezing Policy	☑ New	☐ Revised
	Version-1 was Prepared on: 09-7-2023	
	Version-1 is Approved on: 10-7-2023	
Applicable to: MBBS Program	To be Reviewed on: 10-7-2028	

Statement of the Purpose	To organize leave, excuse, absenteeism and freezing during training in the internship year.
Policy	1. **Leaves during Medical Internship** Medical Intern is allowed for the following leaves, as per Fakeeh College for Medical Sciences policy and procedures: • **Routine annual leave** – 15 days. Annual leave must be submitted at least 30 days ahead of requested dates; the Medical Intern is not allowed to apply for more than 5 days in one placement. • **Emergency leave** – 5 days. This type of leaves is limited for urgent and justifiable reasons. These days can be used at any time. • **Eid Holiday** - 5 days. The Medical Intern is entitled to 5 working days during either Ramadan or Hajj holiday as per the FCMS policy and procedures. • **National Day** - 1 day. 23 September is the Saudi Arabia National Day. • **Foundation day** -1 day. 22 February is the Saudi Arabia Foundation day. • **Sick leave** - If sickness/illness occurred during working hours, he/she should go to the staff clinic at FCMS. A Request must be completed and submitted, with the attached sick leave report, for the approval of Interns specialty coordinator and submitted to the Internship Unit thereafter. **Sick leaves** more than 5 days in Major rotations and more than 3 days in 1-month rotations must be compensated. • **Bereavement leave** - it is leave for the death of an immediate family member, it will be 3 days in case of first degree relative death (mother, father, grandmother, grandfather, sisters, brothers , son, daughter and wife) and in case of husband death it will be (3 month and 10 days) and it will be compensated after the end of internship. • **Educational leave** - for purpose of education , attendance of seminar, workshop and conference , it is allowed to take not more that 3 day inside the kingdom and not more than 5 days outside the kingdom and must be submitted 2 weeks before and certificate must be submitted after that. • Maternity and sick leaves will be compensated after the end of the Internship.

Any leave that exceeds 50% of the working days of any placement will necessitate the placement to be repeated or compensated based on the combined decisions of Interns specialty coordinator and Internship Unit Director.

2. **Policy for Eid vacation:**

- Interns will follow the hospital rules regarding the duration of the vacation.
- During the vacation, you will have normal working days which includes on-call duties.
- For the hospitals that follow the government duration of vacation, the period will be divided to 2-3 parts to allow maximum number of interns to take their Eid vacation.
- Other hospitals that have shorter period of Eid vacation, there will be only one part which include the day of the Eid and 4 days after. Minor adjustments can be done if these didn't interfere with the hospital policy.
- The general rules in applying for Eid vacation are first come, first served and maximum of 50% of interns can take the vacation at any point.
- If all interns of one department at DSFH agreed to take their Eid vacation in different arrangement than the designed parts, that will accepted as long it maintains the 50% rules.

  For example, if there is was 2 periods: 1-5 and 6-10 but ALL interns of a rotation agreed to take 3-7 in which 20 interns out of 40 interns will take their Eid vacation that will be acceptable.

  Interns are not allowed to stop their rotation in order to study for the exam, attending exam or participating in any activity or training that is not part of their internship.

3. **Policy for Annual vacation:**

- Any leave that exceeds 50% of the working days of any placement will necessitate the placement to be repeated or compensated based on the combined decisions of vice dean of clinical affairs and Internship Unit Director.
- A maximum of (5) days leave can only be allowed in any of the four major rotations (Medicine, Surgery, OB/Gyne and Pedia). Leave exceeding the allowed number of days must be compensated.
- No leave can be allowed in Family medicine, ER and Elective rotations. Leave in Family medicine, ER and Elective rotations must be compensated.
- All vacation requests must be submitted to the internship unit one (1) month before the rotation in DSFH or any other affiliated hospital.
- In case of special circumstances that required to submit the request late, special requests must be sent to internship unit explaining the situation with all necessary documentation.
- It is allowed to take only five (5) days in each request per rotation. No division or summation of the vacations within any rotation will be allowed in any circumstances. Any additional days will follow the policy of absences.

- All requests must be submitted to the internship unit within the expected period and the final approval should be taken by the department.
- The intern is fully responsible for retaining the approved request to the internship unit. Failure of the submission will be subjected to disciplinary action which includes repeating part or whole rotation.

  In DSFH, not more than 25 % of interns are allowed to take annual leave at any point of time for major rotations excluding elective. For Eid vacation, the maximum number of interns to take Eid vacation is 50%. Kindly refer to the Eid vacation

4. **Freezing policy:**

- Freezing of Internship rotation for one month only may be allowed during the Internship Year upon request and approval by internship director and the Vice Dean for Clinical Affairs. Requests for freezing should be submitted before the commencement of the Internship rotation or one month prior to the effective date of freezing. Freezing shall always start at the beginning of the Gregorian month. No freezing can be allowed within the rotation.

5. **Delay the start of the internship:**

- The Intern is not allowed to postpone his/her internship year for more than one year from the date of completion of the graduation requirements.
- If the delay is for one to two years, the intern must retake the internal medicine and surgery blocks- when they are held - after the approval of the College Council
- If the delayed period exceeds two years, the intern will repeat the internship program after the approval of the College Council, and no previous rotations will be counted for him/her.

6. **Dropout after training:**

- If the intern drops out of the training with an acceptable excuse for a period of not more than six months, then that period must be compensated at the end of the internship period.
- If the intern drops out with an acceptable excuse for more than six months and for a period not exceeding one year, he shall repeat the entire internship period, after the approval of the College Council.
- If the period exceeds one year, it will be applied with the intern for what applies to the Postponing the start of the internship.

Procedure

Procedure steps	Responsibility

	1. **Leave procedure:** • Applications for emergency leave shall be addressed to executive director of internship unit and the Vice-Dean for Clinical Affairs (VDCA), through the college internship Coordinator, and the reasons for the leave should be clearly specified. • Ramadan and Hajj holidays are considered working days. • Sick-leaves must not exceed 5 days in two-month rotation or 3 days in one-month rotation and needs to be compensated. • Failure to submit leaves early may result in declining request. • Unauthorized leave will be reported to the Vice-Dean for Clinical Affairs by the concerned department. • Unauthorized/Unexcused leave must be compensated after the second warning letters. • Unauthorized /Unexcused leave shall be referred to the Dean of the College for appropriate action which may include repeating one or more rotations.	**Internship unit, VDCA**
	2. **Procedure for freezing:** • Freezing request shall be submitted 1 month before starting the rotation. • Valid excuses only will be accepted, Internship Unit can reject non valid excuses.	**Internship unit, VDCA** **The Dean**
	3. **Delay of the internship and dropout policy** • Delay of the internship request should be submitted 1 month before the internship year • Dropout request should be submitted 1 month before the dropout.	**Internship unit, VDCA** **The Dean**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-27	
Policy Title: Internship Assessment and Evaluation Procedure Policy	☑ New	☐ Revised
	Version-1 was Prepared on: 09-7-2023	
	Version-1 is Approved on: 10-7-2023	
Applicable to: MBBS Program	To be Reviewed on: 10-7-2028	

Statement of the Purpose	1. To identify the rules and regulations of the Internship assessment and evaluation procedure. 2. To outline the roles and responsibilities of all concerned parties involved in the implementation of the internship follow-up, assessment, and evaluation procedure.
Policy	1. This policy provides clear guidelines and procedures for medical interns' assessment and evaluation during internship year.

Procedure

Procedure steps	Responsibility
1. **Planning Phase for internship evaluation** 1.1. Ensuring alignment of "Internship learning outcomes in field specification and the program Learning Outcomes" .	**Internship and students clinical training committee, Medical Education Department (MED)**
1.2. Identify the seven required Entrustable Professional Activities(EPA) during the internship year with identification of milestones.	**Internship and students clinical training committee, MED**
1.3. Alignment of the EPAs with the relevant teaching strategies and assessment methods (Annex 1)	**Internship and students clinical training committee** **MED**
1.4. Identify the learning outcomes and basic procedures in each rotation.	**Relevant faculty member** **Internship and students clinical training committee** **MED**
1.5. Identifying the methods for "Direct and Indirect Assessment" in alignment with LOs.	**Program Director, Assessment Centre (AC), Quality and Accreditation Unit (QAU)**
1.6. Preparing for Indirect assessment measures: (surveys for students, staff,	**QAU**

<table>
<tr><td></td><td>and employers) and selecting methods of data analysis.</td><td></td></tr>
<tr><td></td><td>1.7. Preparation of orientation program that is followed by OSCE to determine the level of student's competence.</td><td>Internship unit</td></tr>
<tr><td></td><td>1.8. Students should attend the orientation program and pass the OSCE with minimum of 60%, so he can be eligible for internship year.</td><td>Internship unit</td></tr>
<tr><td></td><td>1.9. Graduation Office prepares the list of students eligible for starting Internship training and submit to the Program Director.</td><td>Graduation Office</td></tr>
<tr><td></td><td>2. Implementation Phase:
2.1. During each rotation, the interns are assessed according to competence framework (Annex 2)</td><td>Clinical Supervisors/ Consultants</td></tr>
<tr><td></td><td>2.2. Interns are assessed continuously throughout each rotation through the clinical portfolio with the following components:
<table>
<tr><th>Component</th><th>Weight %</th></tr>
<tr><td>Two Mini-CEXs</td><td>30%</td></tr>
<tr><td>Practical/procedural Skills assessment (DOPS)</td><td>30%</td></tr>
<tr><td>Case Based Discussion with evidence-based component</td><td>30%</td></tr>
<tr><td>Personal professional development plan including career planning.</td><td>10%</td></tr>
</table></td><td>Clinical Supervisors/mentors Speciality coordinator</td></tr>
<tr><td></td><td>2.3. At the end of each rotation, In Training evaluation report is filled for each student by consultant. (Annex 3)</td><td>Consultant</td></tr>
</table>

	2.4. The assessment plan for Internship year is as follows: **Rotation** / **Weight** / **Component weight** Internal Medicine / 6% / 3% for portfolio, 3% for ITER Surgery / 6% / 3% for portfolio, 3% for ITER Paediatric / 6% / 3% for portfolio, 3% for ITER Obstetrics and Gynaecology / 6% / 3% for portfolio, 3% for ITER Family Medicine / 4% / 2% for portfolio, 2% for ITER Emergency Medicine / 4% / 2% for portfolio, 2 % for ITER Two Electives / 8% / 2% for portfolio, 2% for ITER, For each elective Domain based OSCE / 50% / Integrated SMLE / 10% / Assessment	**Internship unit**
	2.5. The Medical interns should achieve 75% of the required skills in each rotation, so he can pass to the next rotation	**Medical Intern** **Internship unit**
	3. **Checking Phase:**	
	3.1. The Medical interns should achieve 75% of the required skills in each rotation, so he can pass to the next rotation	**Medical Intern** **Internship unit**
	3.2. Calculating the achievement of rotational learning outcomes	**Specialty coordinator**
	3.3. The results of each rotation shall be calculated by the Theme Leader and submitted to the Internship College Coordinator.	**Theme Leader**
	3.4. The Internship College Coordinator shall compile the results of all rotations and calculate the overall final results for all students within five (5) working days.	**Internship College Coordinator**

	3.5. The Internship Unit Representative shall audit all compiled results within two (2) working days and submit the verified results to the Internship College Coordinator.	**The Internship Unit Representative**
	3.6. The Internship College Coordinator shall forward the audited results to the Head of the Clinical Sciences Department for final review and approval. Upon approval, the results shall be uploaded to PeopleSoft within three (3) working days.	**Head of the Clinical Sciences Department**
	3.7. Discussing the results of field specification learning outcomes in internship and clinical training committee	**Internship college coordinator**
	4. **Analysis and reporting Phase:**	
	4.1. Submitting Field specification report to the program Director to be discussed in MBBS Program Streeting Committee (MPSC)	**Internship college coordinator**
	4.2. Submitting the report to the Medical Education Department (MED) for revision.	**Program Director VDDQM MED**
	4.3. The revised field report will be submitted to QAU along with the action plan to close the assessment loop.	**AC**
	4.4. Communicating results of Learning Outcomes assessment and plan with training faculty staff members.	**Program Director, Internship college coordinator**
	4.5. Implementing plan for closing assessment loop.	**Program Director, Internship college coordinator and speciality coordinator.**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-28	
Policy Title: Internship Tracking Policy	☑ New	☐ Revised
	Version-1 was Prepared on: 09-7-2023	
	Version-1 is Approved on: 10-7-2023	
Applicable to: MBBS Program	To be Reviewed on: 10-7-2028	

Statement of the Purpose	1. To allocate each intern in his/her schedule of clinical rotation during their internship year. 2. To regulate interns' assignment in a specific order during clinical rotation.
Policy	1. A track must include the following rotations: internal medicine, surgery (2 months), obstetrics & Gynecology (2 months), pediatrics (2 months), two electives (1 month each), family medicine (1 month) and emergency medicine (1 month). 2. The Internship Unit must create non-overlapping tracks for internship rotation. 3. Each clinical rotation must start on the first day of Gregorian months. 4. No splitting is allowed in the major rotations of 2-month duration. 5. Major rotation must be taken as general rotation and sub-specialties are not allowed to be chosen unless it was scheduled by the department as internal arrangement. 6. Allocations in affiliated hospitals are not guaranteed and subject to availability of seats in these hospitals. 7. Once the tracking lists are final; no change is allowed whether in the hospital or track. 8. Interns are not allowed to communicate directly with the affiliated hospital regarding acceptance, it must always be done through the Internship unit. 9. Interns should have at least 1 major rotation within DSFH hospital.
Procedure	

Procedure steps	Responsibility
Preparatory Phase	
1. An orientation session regarding tracking must be planned.	**Internship unit director& Program Director**
2. An orientation session must be implemented to students to inform them how to select and apply for the track.	**Internship unit director & Program Director**
Implementation Phase	

	3. A sorting file with details of all tracks must be prepared and revised.	**Internship Unit Executive Director, Program Director & VDCA**
	4. The sorting file must be made available online before 1 July of the year in which students start internship year.	**Internship Unit Executive Director & Program Director**
	5. Students can choose their preferred track and must write 3 choices of the affiliated hospitals for each rotation.	**Students**
	6. After the deadline is reached, the internship unit must sort students in equal numbers in each track according to the GPAs available at that time.	**Internship Unit Executive Director & Program Director**
	7. Tracking students' lists must be announced within one week of receiving the online applications.	**Internship Unit Executive Director & Program Director**
	8. The internship unit must fulfil students' requests of the hospital in the elective and at least one of the major rotations.	**Internship Unit Executive Director**
	9. Official letters must be sent to all affiliated hospitals specifying names and months for each rotation.	**Internship Unit Executive Director & VDCA**
	Evaluation Phase	
	10. A period of one week is allowed for students to appeal their track and provide a reason for changing it.	**Internship unit**
	11. The internship unit must discuss the situation of each appeal and declare the decision within one week of the appeal deadline.	**Internship Unit Executive Director, Program Director & VDCA**
	12. The final tracks and schedules must be announced within one week of the appeal submission and must not be changed.	**Internship Unit Executive Director**
	13. Interns are required to adhere to the designated track and assigned centers throughout their internship. Any intern who refuses to follow the chosen track or changes their assigned center will be subject to a penalty of 3,000 SR per month.	**Internship Unit Executive Director Finance Unit**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-29	
Policy Title: MBBS Preceptorship Policy	☑ New	☐ Revised
	Version-1 was Prepared on: 09-7-2023	
	Version-1 is Approved on: 10-7-2023	
Applicable to: MBBS Program	To be Reviewed on: 10-7-2028	

Statement of the Purpose	To ensure that the clinical preceptors are equipped with knowledge, skills, and attitude in guiding interns in clinical training during internship year.
Policy	1. The roles and responsibilities of clinical preceptors must be outlined and made clear through an orientation program. 2. The clinical preceptor must fulfil the following criteria to be eligible for participation in the program. 2.1 Practicing registrar, senior registrar or a consultant in the corresponding department where clinical training is taking place. 2.2 Willing to participate in the preceptorship program. 2.3 Demonstrate effective communication skills and professionalism. 2.4 Attend the preceptorship program. 3. The preceptor must complete his/her portfolio content including the following: 3.1 Short CV 3.2 Signed job description 3.3 A photocopy of Saudi license. 3.4 A photocopy of the national ID or Iqama. 4. All clinical trainers participating in the program must attend the orientation program planned and conducted by the internship unit and Medical Education Department (MED).
Procedure	

Procedure steps	Responsibility
1. **Pre-training phase**	
1.1. All preceptors must be identified in collaboration with heads of departments, in the affiliated hospitals, and Vice Dean Clinical Affairs (VDCA) in accordance with the selection criteria set and agreed upon by FCMS and DSFH.	**Internship unit, VDCA**
1.2. All identified preceptors list must be sent to the internship unit.	**HOD and VDCA**

	1.3. An orientation program is developed and revised. It must include the learning outcomes expected by the end of each rotation and details of portfolio components.	**Internship unit & MED**
2.	**Implementation Phase**	
	2.1. The preceptorship orientation program is implemented to the targeted list of clinical trainers and HOD.	**Internship unit, VDCA**
	2.2. The program is delivered as hands-on workshop in each of the affiliated hospital or at FCMS as per the availability.	**Internship unit, MED & VDCA**
3.	**Evaluation phase**	
	3.1. At the end of the program each preceptor must submit a reflection form and a self-evaluation form.	**Internship unit, VDCA**
	3.2. All attendees receive a certificate of attendance and completion.	**Internship unit, VDCA**
	3.3. A report about the conducted program is submitted to be discussed in the Internship and Clinical Training Committee and MBBS Program Steering Committee.	**Internship unit, VDCA**
4.	**Monitoring stage**	
	4.1. Feedback forms regarding the efficiency of the program in preparing preceptor to their job, are submitted at the end of internship year.	**Internship unit, VDCA**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-30	
Policy Title: Internship Training Program	√ New	☐ Revised
	Version-1 was Prepared on: 18-5-2023	
	Version-1 is Approved on: 21-5-2023	
Applicable to: MBBS Program	To be Reviewed on: 21-5-2028	

Statement of the Purpose	To establish guidelines for training of "MBBS Internship Program" at Fakeeh College for Medical Sciences (FCMS).
Policy	1. All students enrolling into an "Undergraduate Program", after the completion of their academic study must complete an "Internship Training course". 2. MBBS students after completion of their 6 years of academic study, must complete an "Internship Training" for a period of one year (12 months).

Procedure

Procedure steps	Responsibility
1. After completing the required credit hours for the Program and the acquired GPA, students are eligible to enroll in the "Internship Training Program". 2. Students will complete their "Internship Training" at Dr. Soliman Fakeeh Hospital or its associates, King Fahad Armed Forces Hospital (KFAFH), National Guard Hospital (NGH), and Ministry of Health(MOH) Hospital and exceptions are allowed in special cases only after the approval from College Council. 3. Students can receive their schedule from the College "Internship Coordinator" assigned for the MBBS Program. 4. Students will be assigned to a qualified Mentor/preceptor from the training hospital and their progress will be closely monitored by the College coordinator or supervisor. 5. The "Internship Training Program" is considered complete based on the student's achievements.	**Internship Unit at FCMS**

	6. The interns will be evaluated at the end of each clinical rotation by testing the earned clinical skills and experiences according to the "Internship Program Manual" and by **MINI-CEX** and case-based discussion.	**"Resident, senior registrar or consultant"**
	7. **Attendance** 7.1. Attendance for the whole internship period [12 months] is mandatory. 7.2. Field Internship coordinators (FIC) or preceptors are authorized to allow interns to "make up" a late arrival at work on the day of the occurrence if there is a valid excuse or it will be considered as an unexcused absence. 7.3. Any absence must be reported by the hospital internship coordinator /preceptor to the ICC. 7.4. The offending intern will be counseled by the ICC and the incident will be reported to the program director. 7.5. The intern who is absent one day of any rotation will receive the first warning letter (unexcused absence) and will be required to repeat the missed day of the rotation. 7.6. The intern who is absent two of any rotation will receive the second warning letter (unexcused absence) and will be required to repeat the missed days of the rotation. 7.7. The intern who is absent more than 2 days of any rotation will receive the third warning letter (unexcused absence) and will be required to repeat the entire rotation at the end of the program regardless of the reason. 7.8. The intern student will receive a warning letter in the following situation(s): ➢ Uncooperative attitude ➢ Misbehavior ➢ Dress code violation ➢ Late arrival ➢ Unauthorized absences	**Intern Student** **FIC** **ICC**

	➢ Leaving the training site without informing the preceptor 7.9. If intern students receive 2 warning letters during the internship year, the student will be referred to the internship unit director. 7.10. In the event of sudden illness: • The intern student is entitled to a maximum of 12 days of sick leave throughout the internship year. • Only a sick leave report certificate approved by DSFH staff clinic doctors and from a government hospital will be accepted. • Notifications/letters from private Hospitals/Clinics are **NOT** acceptable. • A phone call must be made to the assigned unit, the interns' hospital coordinator, and the clinical preceptor to inform them about the sick leave. • When the intern student reports back on duty, he/she will have to submit the sick leave to the FIC for final approval. • In case sick leave is not accepted, the intern student will have to repeat the missed days in the area of assignment. • Other acceptable absences as lifetime events and/or family emergencies, an intern is allowed for 3 days during the internship year. • The intern is not allowed to take more than 2 types of leave in the same placement to a maximum of 7 working days. 7.11. Any non-approved absences will be subjected to disciplinary actions. Any non-approved absences from on-call absences will be subjected to the repetition of placement/rotation.	
	8. **Passing Grade** 8.1. In order to certify that the intern student successfully completed his/her training program, student must pass all internship exams and must obtain a minimum score of **70%** in the post-internship exam; otherwise, student will be considered as failed.	**Internship Unit**

	9. **Violation and action** 9.1. If violation done by the intern and submitted to the internship unit through the clinical coordinators or through the affiliated hospitals should be discussed in internship unit and it will be raised to MBBS Program Steering Committee (MPSC) Institutional internship and clinical training Committee for discussion, and college council.	**Internship unit Executive director** **Internship unit Executive director** **MPSC** **Vice Dear for Clinical Affair** **Vice Dean for Academic Affair**
	10. **Hospital transfer:** 10.1. There are no changes permitted in the schedule after submitting the final schedule in the internship unit (either electronically or paper format). 10.2. Special circumstances in which changing part of the schedule cold be allowed are as follow: A. Interns are allowed to make schedule changes within DSFH hospital if the request for a change was 1 month before the rotation starts provided that there is availability in both rotations. B. No changes are allowed from any affiliated hospital after sending the requests whether accepted or still pending. If there was a strong documented & legitimate reason for such changes the document must be applied 2 months before the rotation starts and hospital transfer form must be filled. C. Changing the rotation within the affiliated hospitals or switching the rotation between the interns and the periods are generally allowed under 2 conditions: • Application must be applied 2 months before the rotation starts. • Acceptance by the affiliated hospital of the interns switching requests will not be processed until 2 signed requests are provided. 10.3. Interns are not allowed to communicate directly in an official manner to affiliated	**Internship Unit**

	hospitals and all changes must be accepted only through the internship unit. 10.4. The evaluation from any hospital will be accepted based on the internship office records. In case of changes made by the intern without requesting properly from the internship unit, the intern will repeat the whole rotation and will be subjected for other academic penalties. 10.5. If the intern has a strong documented, legitimate and valid reason for transfer, he/she should follow the following procedure: • Fill in the required form and attach all the requirements. It should be at least 2 months before transfer • Acquire written acceptance from the current and new hospital • Apply for transfer approval through internship unit • Seek written approval from internship unit	
	11. **Final clearance process:** 11.1. In order to complete the internship training and issue a bachelor's degree certificate an overall evaluation for the whole internship year must be completed by the ICC and reviewed and approved by the program director. 11.2. A list of students who are eligible for graduation will be discussed and approved in the Department Council and College Council. 11.3. This list will be submitted to the college Graduation Office to issue the certificates.	**Internship Unit** **Program director**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-31	
Policy Title: Professional Code of Conduct for Interns	√ New	☐ Revised
	Version-1 was Prepared on: 21-5-2023	
	Version-1 is Approved on: 22-2-2023	
Applicable to: MBBS Program	To be Reviewed on: 22-2-2028	

Statement of the Purpose	1. To specifically address the issues and concerns regarding the behavior, attitude, and appearance of interns during their internship program, starting from the registration until the release of grades. 2. To demonstrate professional behavior in their interactions with each other, as well as with students, patients, other trainees, colleagues from other health professions, and support staff. 3. To respect patients and their relatives and considering their dignity.
Policy	1. **Dress code policy:** Identification badges must be always worn. a. Identification badges are to be clearly visible, above the waist. b. Identification badge holders may be worn if not interfering with patient care and safety. 2. **Hair:** For men, hair must be kept clean, neatly groomed and controlled. a. Long hair must be secured away from the face. b. Extreme styles and colors are not permitted. c. Fashionable head bands or caps are not permitted. For ladies, hair must be covered as per the Shariaa law: a. Head scarves shall not interfere with patient care and safety. b. Scarves shall not be loose for modesty and safety. c. Bright colors and glittery designs are not acceptable. d. Black, white, or neutral colors shall be used. 3. **Nails must be short, neat, and clean, to avoid irritating patients during clinical examination.** a. Nail polish and decorative designs are prohibited. b. Artificial fingernails are not allowed for all staff and students in contact with patients. 4. **Jewelry:** must be plain and inconspicuous. a. Jewelry must not interfere with patient care or safety. b. Necklaces are NOT permitted for men. c. Bracelets or armbands are not permitted unless they are a Medical Alert bracelet. d. Only one ring or ring set is allowed. e. Well-fitting, not loose, wristwatch is permitted. f. Facial piercing jewelry (i.e., eyebrow, nose, tongue, lip, etc.) is prohibited.

5. **Fragrance is not to be used in the hospital and patient care areas.**
6. **Footwear** should be clean, appropriate for clothing, protective and fit securely.
    a. Shoes should be non-permeable.
    b. Shoes must have a closed toe and closed heel.
    c. Canvas shoes or "crocs" with holes are not permitted in patient care areas. Shoes and shoelaces must be kept clean. Staff must always wear hosiery or socks.
    d. Cloth stethoscope covers, or decorative items attached to stethoscope are not permitted.
7. **Uniform/Clothing Standards:**
    a. Intern must be worn and inconspicuous under uniform or clothing.
    b. Clothing must be clean and neatly pressed.
    c. Faded / yellowish, discolored, or ripped clothing is not acceptable.
    d. All clothing should be non-see through.
8. **Smoking is not allowed in the hospital**
   Regular and E-Cigarettes are strictly prohibited in the hospital.
9. **Reporting Responsibilities:**

Physicians involved in the internship training shall report to the director of the internship unit and the Vice dean of clinical affairs (VDCA).

It is the responsibility of the preceptor and or hospital/college internship coordinator to promptly report if an intern exhibit any of the following:

a) Attitudes indicating disrespect, abuse, or exploitation of a patient.
b) Failure to interact with patients professionally and ethically.
c) Unprofessional and or unethical attitudes towards supervisors or colleagues.
d) Engagement in inappropriate behavior at the hospital premises.
e) Obstacles to the acquisition of medical and clinical experience.
f) All procedures must be directly supervised by eligible staff, after the correct consent from the patient, failure to do so can lead to disciplinary action which can lead to expulsion from the training program.

10. **Professionalism**

a) Interns must report their internship related issues in writing to the FCMS Internship Unit(IU).
b) Interns are required to treat thee staff and their colleagues with respect at all the times.
c) Interns are expected to be in their best professional behavior, proper code of conduct and appearance during the internship program as they represent FCMS.
d) Interns must familiarize, adhere to, and comply with the set rules, regulations, policies, and procedures of the training hospital, FCMS and the assigned Academic Supervisors.
e) Interns must display initiative and foresight to work with supervision and flexibility in a diversified workplace.
f) Interns must be proactive and display strong leadership and teamwork skills.
g) Interns must possess good writing, verbal and listening skills.

8. Interns should always dress appropriately at work.
9. Interns must maintain a highly professional way of communication. The use of abusive, vulgar, or profane language is not allowed.
10. Interns should not quit the workplace in case of possible encountered problems unless it is recommended by their respective academic supervisor in writing.
11. Interns should return items such as reference material, laptops, parking cards, etc. on the last day of internship program.
12. The use of illegal drugs, alcohol and weapons is strictly prohibited. And this will not be allowed under any circumstances, and anyone caught doing so will be dealt with the corresponding disciplinary action and legal proceedings.
13. The use of violence, inflicting harm, threatening, and coercing co-workers at the workplace is strictly prohibited.
14. Any damage, loss, theft or destruction to property in the workplace is the sole responsibility of the intern. The intern must compensate/indemnify for items lost or damaged be it accidental or intentional in nature.

Procedure

Procedure steps	Responsibility
Implementing MBBS internship code of conduct policy: 1. Uniforms for FEMALE: scrub suit, white scarf covering the hair, white lab coat with embroidered college logo, white socks and white or gray duty leather/rubber shoes. 2. Uniform for MALE: scrub suit with embroidered college logo, white t-shirt, white socks and white or gray duty leather/rubber shoes. 3. The clinical uniform is worn only in proper places or occasions, such as during officially scheduled clinical duty, whether at DSFH or in affiliating agency and when attending professional meetings or conferences as prescribed. 4. Decorum is always expected and, in all places, while in clinical uniform. 5. Jewelry, such as rings, necklaces, bracelets, dangling earrings, anklets, and other accessories should not be worn while in clinical uniform. Only wedding bonds and rings will be allowed.	**Vice Dean for Clinical Affairs** **Executive Director of Internship Unit** **Clinical sciences Head of Department (HOD)** **MBBS Program director** **MBBS Internship Coordinator**

	6. Fancy-designed, colored wristwatches are not allowed. Plain gold, silver-plated, or leather strapped watches with second-hand are recommended for use. 7. Hair style for females must be simple, tied and fixed with a bun/hairnet. Hair should not fall on the face upon stooping. 8. Long hair, any hair dyes or highlights are not allowed for male nurse interns. 9. Fingernails must be trimmed and clean for both male and female, nail polish and artificial nails is strictly prohibited for female. 10. Beards and mustaches should be trimmed and look neat. 11. Light make-up for female is acceptable, full make up such as extreme eye shadow and blush on colors and wearing fall eyelashes and contact lenses is not allowed.	
	12. Ensure the implementation of the policy.	**Internship Unit, College Internship Coordinator, and Hospital Internship Coordinator**
	13. **Monitoring and Overseeing:** Monitoring and overseeing the code of conduct of the medical interns during their clinical affiliation in the hospital.	**The MBBS Internship and clinical Training Committee, Clinical sciences Head of Department (HOD) Vice Dean for Clinical Affairs IQAS Team**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-32	
Policy Title: Governance policy	☑ New	☐ Revised
	Version-1 was Prepared on: 21-5-2023	
	Version-1 is Approved on: 22-2-2023	
Applicable to: MBBS Internship Year	To be Reviewed on: 22-2-2028	

Statement of the Purpose	To provide guidelines and regulations in which Fakeeh College for Medical Sciences (FCMS) conduct and manage the clinical training and education during internship year.
Policy	1. This policy is to identify the system through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards of training and education by creating an environment in which clinical excellence can be achieved.

Procedure

Procedure steps	Responsibility
1. The Medical Internship (MI) is governed by the Internship Unit (IU) under the umbrella of Clinical Affairs, at FCMS.	**Internship unit**
2. The IU ensures the presence of clear governance of internship year with clear roles and responsibilities for each involved staff.	**Internship unit**
3. The internship college coordinator reports all the recommendations and suggestions relevant to the implementation of internship year to program internship and clinical training Committee (PICTC).	**The internship college coordinator**
4. The PICTC is responsible for discussing all the issues and items related to the implementation of the internship year.	**PICTC**
5. The PICTC members meet monthly to monitor and follow up the implementation of the internship year.	**PICTC**
6. PICTC-chairperson reports to the program Director and Head of Clinical Sciences Department and IU.	**PICTC-Chair**
7. Program Director reports to the MBBS Program Steering committee (MPSC)	**Program Director**

	8. The MPSC reports to Institutional Internship and Student Training Committee (IISTC)	**MPSC-Chair**
	9. IISTC chairperson reports to the College Council	**IISTC-Chair**
	10. The IU ensures the fulfilment the responsibilities as follows:	
	10.1. Clinical Supervisor (senior registrar/specialist) ➢ Provide orientation to the medical interns including the following: • the stage of training and responsibilities of the intern • the location of educational resources. ➢ organize and supervise the medical interns during their training rotation at an appropriate level. ➢ acts as a link between medical interns and consultants. ➢ observe intern's performance directly with discussions on common and emergent clinical problems. ➢ Demonstrate clinical procedures for Medical Interns. ➢ Review and discuss reflective journals and overall education with the medical intern should discuss as well as perceptions of clinical strengths and weaknesses. ➢ Help interns to be self-directed learners through monitoring their PDPs and giving constructive feedback. ➢ Train interns in assigned clinical placement. ➢ Monitor intern's performance. ➢ Conducts case-based discussion. ➢ Monitor the Medical interns' attendance on a daily basis. ➢ Participate in DOPS and Mini- CEX provide professional education and clinical training of Interns, including ethical issues, career guidance, self-education.	**Clinical Supervisor (senior registrar/ specialist)**
	10.2. Specialty/ Placement coordinator ➢ Make visits on a weekly basis and submit weekly progress report. ➢ Monitor achievement of learning outcomes	**Specialty/ placement coordinator**

	➢ Review students' clinical portfolios. ➢ Monitor intern's performance. ➢ Observe the conduction assessment (DOPS, Mini-CEX, and rotation Exams) if needed/applicable. ➢ deal effectively with other staff and specialists and medical interns. ➢ demonstrate commitment to the development of the profession. ➢ The specialty coordinator is encouraged to receive feedback from rotating medical interns on the following aspects: - The range and effectiveness of clinical teaching, training and support provided for them. - The degree of support and supervision given to them to achieve learning outcomes. - Training opportunities and level of supervision. - The support on addressing performance issues and conflict resolution.	
	10.3. Internship hospital coordinator: ➢ Collaborate in implementing internship year. ➢ Facilitate hospital orientation program. ➢ Schedule intern's activities ➢ Plan for clinical rotations for interns' assignment ➢ Initiate and maintain all interns' documents. ➢ Follow up the medical intern's attendance.	**Internship hospital coordinator**
	10.4. College coordinator: ➢ Collaborate in implementing internship year. ➢ Scheduling interns' activities. ➢ Report to the PICTC. ➢ Prepare Annual Field Experience Report and Filed Specification and discuss it with PICTC. ➢ Coordinate counseling of interns if needed. ➢ Facilitate college and hospital orientation program. ➢ Record and archive interns' profile. ➢ Coordinates in scheduling medical interns' activities. ➢ Follow up and mentor interns' attendance and progress.	**College coordinator**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-33	
Policy Title: SMLE Preparation Program	☑ New	☐ Revised
	Version-1 was Prepared on: 18-05-2023	
	Version-1 is Approved on: 22-2-2023	
Applicable to: MBBS Program	To be Reviewed on: 22-2-2028	

Statement of the Purpose	To familiarize the students with Saudi Medical License Exam (SMLE) preparation program to get high scores in the formal SMLE.
Policy	1. The program covers all disciplines in SMLE. In addition, during the program students are introduced to practice tests that imitate the actual examinations held in Saudi Commission for Health Specialists (SCFHS). These practice tests are held to enable the candidates to live the experience the real examinations and to analyse and overcome the stressful situations. Moreover, the tests train the students to face the most challenging situations. The program is delivered for interns, 6th year and 5th year medical students separately. The program will be delivered for undergraduate students all over the academic year and for interns all year around.

Procedure

Procedure steps	Responsibility
1. The designing of the SMLE program, the development of teaching materials and preparation of the exam questions must be completed minimum one month before the starting date of the program.	**Program Director** **Medical Education Department (MED)** **Assessment Center (AC)** **SMLE Taskforce Members**
2. Students will be introduced to test-taking strategies (critical thinking strategies, prioritization strategies).	**SMLE Taskforce Members** **MED** **AC**
3. The program also, covers intensive study program in which contents are delivered from all the specialties in medical sciences as per approved study plan and curriculum within FCMS and blueprint of the SMLE.	**Program Director** **Faculty staff members** **MED**
4. Faculty staff members are assigned to deliver specific topics according to a structured program within their specialization.	**Program Director** **Faculty staff members** **MED**

	5. The program includes regular computerized training tests on numerous questions prepared by faculty staff members in alignment with SMLE blueprint.	**SMLE Taskforce Members** **Program Director** **Faculty staff members AC**
	6. Students must answer these questions by themselves and achieve at least 95% score or more to be allowed to enter the formal SMLE.	**College Management** **SMLE Taskforce Members** **Program Director** **AC**
	7. Students are given feedback following their tests.	**SMLE Taskforce Members** **Clinical Instructors**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-34	
Policy Title: Development and Review of Field Experience Specification and Report	☑ New	☐ Revised
	Version-1 was Prepared on: 18-05-2023	
	Version-1 is Approved on: 22-2-2023	
Applicable to: MBBS Internship	To be Reviewed on: 22-2-2028	

Statement of the Purpose	To establish the guidelines on the submission and review standards of field experience specification and report.
Policy	1. Organizing and managing the time wisely in the process of submitting the field experience specification and report document on a set deadline will be monitored by the MBBS Internship and Clinical Training Committee.

Procedure

Procedure steps	Responsibility
1. Completion of the field experience specification development.	**College Internship Co Ordinator, Executive Director of Internship Unit.**
2. Review and approval of the field experience specification must be done (1) month before the beginning of the academic year.	**MBBS Internship and Clinical Training Committee, Clinical Sciences Department. VDCA.**
3. The reviewed field experience specification format will be submitted and discussed in the MBBS Program Steering Committee for a period of one (1) week.	**MPSC**
4. The approved version of field experience specification will be sent to the Medical Education Department (MED) for further review and will be sent to the Quality and Accreditation Unit (QAU) for final approval in a week before the start of the internship year.	**MED QAU**
5. The field experience specification once reviewed by the MED and QAU will be approved at the Institutional Curriculum	**I-CRMC CC**

	Review and Monitoring Committee(I-CRMC) and the College Council(CC).	
	6. At the end of the internship year the field experience report must be accomplished.	**College Internship Coordinator.**
	7. Review and approval of the field experience report must be done within 1 month after the end of the academic year.	**Executive Director of Internship Unit, MBBS Internship and Clinical Training Committee, Clinical Sciences Department VDCA**
	8. The reviewed field experience report will be submitted and discussed in the MPSC for a period of one (1) week.	**MPSC**
	9. The approved version of field experience report will be sent to the MED for further review in a period of one (1) week and will be sent to the QAU for final approval.	**MED QAU**
	10. The field experience report once reviewed by the MED and QAU will be approved at the Institutional Curriculum Review and Monitoring Committee(I-CRMC) and the College Council(CC).	**I-CRMC CC**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-35	
Policy Title: Internship-Follow-up and Supervision Policy	☑ New	☐ Revised
	Version-1 was Prepared on: 09-05-2023	
	Version-1 is Approved on: 28-5-2023	
Applicable to: MBBS Program	To be Reviewed on: 28-5-2028	

Statement of the Purpose	1. To establish mechanism for monitoring the internship year implementation including follow-up and supervision. 2. To implement the follow-up and supervision mechanism and to ensure that the interns' performance is regularly appraised towards the achievement of the learning outcomes.
Policy	1. This policy is designed to describe the mechanism of the follow-up and supervision process during the internship year. It tends to explain the responsibility of all staff involved as well as ensuring regular monitoring of the interns and to identify areas that need improvement.

Procedure

Procedure steps	Responsibility
1. Follow up and supervise the interns based on their specialty (Internal medicine, general surgery, pediatric, obstetrics & gynecology, special, and subspeciality departments). 2. Evaluate the interns based in the approved Rubric format, giving the intern score that will be calculated toward the final evaluation of the intern.	**Specialty Consultant Specialty Senior Registrar/Resident**
3. Discuss about the training objectives with the interns and ensure intern's understanding about the principles and procedures of the test performed. 4. Complete the 'weekly "follow-up form' for 1-month rotations, and monthly for major rotations and present it to the Internship Unit for discussion and early identification of weaknesses. 5. Ensure the completion of clinical portfolio. 6. Mid rotation, End of rotation regular meetings and portfolio completion and evaluation.	**Theme Lead Coordinator**

	7. Report any delay or no show of the interns in their regular meetings to the internship unit	
	8. Daily visit DSFH and weekly distant site. 9. Check attendance, compliance to professionalism, follow their schedule. 10. Check the dress code and appearance of the interns and report the cases of violation. 11. Raise incidents and issues to the internship unit. 12. Report the weekly attendance of the interns and report the cases of absenteeism via email to the internship college coordinator and warning letters shall be sent to the absent students on regular basis.	**Clinical Coordinator**
	13. Monthly meeting with interns Internship unit VDCA to discuss Provide all necessary information and feedback that support improvement of the training year.	**College Interns Coordinator** **Executive Director of Internship Unit** **Head of Clinical Sciences Department** **Program Director VDCA**
	14. Monthly meeting with DSFH and distant site to check, follow up.	**Internship Unit Head of Clinical Science** **Program Director VDCA**
	15. Satisfaction survey will be distributed after each rotation to get intern feedback .	**Quality and Accreditation Unit**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-36	
Policy Title: Intern Reward and Recognition	☑ New	☐ Revised
	Version-1 was Prepared on: 28-1-2024	
	Version-1 is Approved on: 29-1-2024	
Applicable to: FCMS	To be Reviewed on: 29-1-2029	

Statement of the Purpose	To motivate the Fakeeh College for Medical Sciences (FCMS) interns to improve their performance during internship training.
Policy	1. FCMS supports and acknowledges the special achievements by intern that enhance institutional and programs goals and objectives through structured reward and recognition procedures. 2. An intern has the right to nominate himself/herself for reward and submit nomination form to the College internship coordinators or director of internship unit. 3. Reward Taskforce team will evaluate the candidates with supporting evidences, and make final recommendations to the Internship and Student Training Committee for approval. 4. The following are the criteria for the best intern award nomination: • High score in DOMAIN Based OSCE > 90 score: 4 points, 80-89:3, 70-79-2, 60-69-1. • High score in SMLE > 90 score: 4 points, 80-89: 3, 70-79-2, 60-69-1. • High score in evaluation and portfolio > 90 score: 4 points, 80-89:3, 70-79-2, 60-69-1. • Took the role of chief intern for one month: 2 points. • Participating in Community engagement activities during the internship: 2 points. • Participating in professional development activities during the internship: 2 points. • Participating in scientific research activities during the internship: 2 points. • No complain / absenteeism / compensation / repetition during the internship: 3 points. • Professional behavior and communication : 2 points. 5. Each year 3 interns will be selected from the submitted nominations for reward. **1- Participating in Community engagement activities :** Actively participates in the community services activities organized by the College or other organization as participant or leader. **2- Participating in professional development activities:** Actively participating and presenting topics as part of professional development program (internal or external)

3- Participating in scientific research activities:

A member in the research group and actively participating in scientific research activities.

4- Professional behavior and communication:

- Communicates effectively with seniors and colleagues.
- Interacts with others in a positive, enthusiastic, and cheerful manner.
- Treats other interns, supervisors, and faculty, students with respect.
- Punctuality and commitment (in DSFH and distant hospitals).
- Commitment to submit the portfolio and other documents on time.
-

Procedure

Procedure steps	Responsibility
1. At the end of the year, the internship unit director will announce college-wide and invite nominations for inter reward.	**Internship Director**
2. Reward Taskforce team will review and evaluate each nominee's information and levels of excellence.	**Reward Taskforce Team**
3. Reward Taskforce team will select the eligible candidates from the nomination for rewards. Three of the best interns will be selected for a reward each year and forward the recommendations to the Internship and Student Training Committee.	**Reward Taskforce Team**
4. The selected interns' names will be sent to the College Dean for final approval of reward.	**College Dean**
5. Once approval is received, it will be sent back to the Internship Unit for implementation/ processing if it will include monetary rewards.	**Internship Unit**
6. The name and photograph of the selected interns will be announced and published through FCMS notice board by the Media and Public Relation Unit.	**Media and Public Relation Unit**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-37	
Policy Title: Observership policy of second year undergraduate medical students	☐ New	☑ Revised
	Version-1 was Prepared on: 12-8-2021	
	Version-2 is Approved on: 10-8-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 10-8-2029	

Statement of the Purpose	Ensure that the medical students receive adequate and structured clinical effective training in a hands-off setting.
Policy	1. This policy provides a structured framework for clinical observership for undergraduate medical students

Procedure

Procedure steps	Responsibility
Clinical observership starts at the 2nd year of undergraduate medical education and it includes the following steps:	
1. Preparation Phase:	
1.1. Develop and schedule clinical rotations. 1.2. Complete student registration, ensuring all required documents are submitted. 1.3. Verify student health insurance coverage. 1.4. Ensure students complete the 'Second Year Medical Student Affiliation Checklist' (Annex-2). 1.5. Confirm that students have signed the code of conduct, confidentiality, and safety forms (Annex-1). 1.6. Conduct orientation sessions for students before the observership begins.	**Administration**
2. **Implementation Phase**	
2.1. Ensure students adhere to safety measures in the clinic.	**Consultants & Nurses**
2.2. Provide brief explanations or summaries relevant to the observation (if applicable). 2.3. Answer students' questions outside of patient interactions.	**Consultants**
2.4. Sign students' clinical portfolios (daily cases observed). 2.5. Facilitate debriefing sessions (two	**Residents**

residents per 15 students). 2.6. Discuss at least one observed case per student in debriefing sessions. 2.7. Provide students with constructive feedback. 2.8. Evaluate students' participation and engagement. 2.9. Collect and review students' debriefing reports and reflections (Annex 4 & 5). 2.10. Submit a summary report on the observership process to the year coordinator at the end of the rotation.	
2.11. Demonstrate best practices in vital signs measurement. 2.12. Ensure students follow safety regulations.	**Nurses**
2.13. Attend all assigned sessions and fully observe clinical interactions. 2.14. Record observed cases in the clinical portfolio (Annex-3). 2.15. Avoid patient interaction or interference in clinical consultations. 2.16. Maintain professional conduct and adhere to confidentiality guidelines. 2.17. Write reflective journals and debriefing reports based on shadow files (Annex 4 & 5).	**Students**
3. **Evaluation Phase**	
3.1. Assess students' clinical portfolios.	**Residents & Consultants**
3.2. Evaluate student satisfaction with the observership experience (Annex-7). 3.3. Gather feedback from residents and consultants (Annex-8 & 9).	**Administration**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-38	
Policy Title: Students' Portfolio in Undergraduate Medical Education	☑ New	☐ Revised
	Version-1 was Prepared on: 14-10-2018	
	Version-2 is Approved on: 13-10-2023	
Applicable to: MBBS Program	To be Reviewed on: 13-10-2028	

Statement of the Purpose	1. To establish a well-structured framework for designing and implementing the Student's portfolio, to enhance their professional development within and beyond Medicine. 2. To monitor and evaluate the effectiveness of Students' Portfolio in achieving its needed outcomes.
Policy	1. This policy provides a structured framework for effective implementation of undergraduate medical students' portfolio. 2. The Students' Portfolio is integrated into clinical/practical courses constituting fifteen percentage of the total course grade.

Procedure

Procedure steps	Responsibility
1. **Planning Phase**	
1.1. Define the objectives and content of the Students' Portfolio.	**Assessment Center (AC)**
1.2. Develop the electronic portfolio (e-portfolio) with three main sections: concept appraisal case report, assignments, and reflections.	**Assessment Center (AC)**
1.3. Conduct student orientation on the portfolio's purpose, structure, and evaluation criteria.	**Course Coordinator**
1.4. Train faculty members on portfolio assessment methods and grading criteria.	**Assessment Center (AC)**
2. **Implementation Phase**	
2.1. Ensure the portfolio content is tailored to each course. 2.2. Ensure that the main items are concept appraisal cases, assignments, and reflections, along with additional items such as	**Course Instructor**

	• Products of students work such as: reports, assignments, patient management plan • Evidences of work such as: observation report, photographs or videos • Evaluations such as feedback forms or observational checklist	
	2.3. Upload reports, assignments, and reflections to Blackboard.	**Students**
	2.4. Submit reflections, documenting competencies acquired using the Reflective Journal Template (Annex-1).	**Students**
	2.5. Develop an individualized improvement action plan based on academic performance and progress.	**Students**
	3. **Mentoring Phase**	
	3.1. Assign each student a mentor (academic staff or senior peer).	**Course Coordinator**
	3.2. Conduct mentor-student meetings every three weeks to track progress and provide guidance.	**Mentor**
	3.3. Assess and grade the report based on the model answer.	**Course Instructor**
	3.4. Monitor students' overall progress throughout the course.	**Mentor**
	3.5. Provide students with timely and constructive feedback on their performance.	**Mentor**
	4. **Evaluation Phase**	
	4.1. Assess and grade the report according to the model answer.	**Course Instructor**
	4.2. Evaluate assignments based on predefined rubrics.	**Course Instructor**

	4.3. Assess students' reflections using the established rubric.	**Mentor**
	4.4. Finalize portfolio grading and provide students with their overall score at the end of the semester.	**Mentor**
	4.5. Offer students structured constructive feedback to support their academic and professional growth.	**Mentor**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-39	
Policy Title: Problem Based Learning (PBL) in Undergraduate Medical Education	☐ New	☑ Revised
	Version-1 was Prepared on: 10-10-2018	
	Version-2 is Approved on: 10-10-2024	
Applicable to: MBBS Program	To be Reviewed on: 10-10-2029	

Statement of the Purpose	To ensure that the Problem Based Learning (PBL) sessions are conducted properly and effectively.
Policy	1. This policy provides structured framework for problem-based learning as a way of teaching and learning. 2. PBL consists of three sessions: Brainstorming session, Multidisciplinary seminar and Debriefing session. 3. Five percent of the course grade is allocated to PBL sessions.

Procedure

Procedure steps	Responsibility
1. Establish the PBL team membership: 1.1. PBL team is composed of a representative from each discipline included in block or module. 1.2. PBL team is responsible for case construction and tutor guide construction.	**Course Coordinator**
2. Case constructions: 2.1. Identify the students' learning outcomes addressed in PBL session. 2.2. Construct a template for 'case' description to ensure that the 'cases' address cognitive skills. also, to create cases that follow the same design and sequence. 2.3. Integrate multiple disciplines with identifying cues 'A trigger points may be written or visual' that foster and enhance students' discussion. 2.4. Adjust the 'case' to the defined learning outcomes. 2.5. Ensure that a dedicative approach is applicable.	**PBL team**

	2.6. Ensure students' engagement with the 'case' through building it on their prior knowledge.	
	3. Tutor Guide construction: 3.1. The tutor guide is constructed based on the designed template (See Annex 1.) and it includes: 3.1.1. The case scenario 3.1.2. The students' learning objectives. 3.1.3. Background information and explanatory notes on the focus of the 'case'. 3.1.4. Point of emphasis and de-emphasis and point of review. 3.1.5. Facilitation questions. (to guide tutor or facilitator)	**PBL team**
	4. Training of academic staff on PBL process, tutor role and assessment	**PBL team**
	5. Training of students on PBL process and assessment.	**PBL team**
	6. Implementation of PBL: 6.1. Divide students into groups, each group contains 7-10 students. 6.2. Assign each group one tutor or facilitator to guide the students' discussion. 6.3. Provide each student with the case scenario. 6.4. Ensure the facilitator has the relevant tutor guide for the session. 6.5. The first session is the brainstorming session where all students with the tutor/facilitator set their ground rules and assign roles to the group members (leader and scribe). They discuss the case with the facilitator and the session lasts one hour. 6.6. The second session is the debriefing session where students share their findings with the group members and integrate the acquired knowledge into a comprehensive explanation of the phenomena or problem.	**PBL team**
	7. Evaluation of PBL: 7.1. **Tutors evaluate** students using 'PBL rubric' (See Annex 2). 7.2. Students evaluate tutor using 'Tutor Evaluation Rating Scale' (See Annex-3).	**Tutors & Students**

7.3. Conduct self and peer evaluations of students using stated criteria (See Annex-4). 7.4. Evaluate staff perceptions of PBL process using a designed questionnaire (See Annex.5)	
8. Tutor Role 8.1. Identify the Ground rules of the sessions with the students. 8.2. Discuss role play with students. 8.3. Guide the students' discussion in PBL sessions. 8.4. Guide students to identify their learning needs. 8.5. Build trust and encourage bonding of group members. 8.6. Use facilitation questions to direct the discussion. 8.7. Assess students' performance (knowledge, skills and attitude) in PBL sessions according to PBL tutorial session assessment and its rubric (See Annex 6.2.) 8.8. Provide feedback to students about their performance.	**Tutors**
9. Student Role 9.1. Participate actively and effectively in PBL sessions. 9.2. Identify their learning needs based on problem discussion. 9.3. Share their findings with the group and try to integrate the knowledge acquired into a comprehensive explanation of the phenomena or problem. 9.4. Answer five integrated questions at the end of the debriefing session. 9.5. Conduct peer performance using the stated criteria (See Annex-6.4.) and provide feedback. 9.6. Evaluate tutors /facilitators using the designed scale.	**Students**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-40	
Policy Title: Clinical Training Summer School	√ New	☐ Revised
	Version-1 was Prepared on: 19-5-2024	
	Version-2 is Approved on: 20-5-2024	
Applicable to: FCMS	To be Reviewed on: 20-5-2029	

Statement of the Purpose	To outline the structure, procedures, and expectations of the Clinical Training Summer School at Fakeeh College for Medical Sciences (FCMS), ensuring a high standard of education and hands-on training in a clinical setting.
Policy	1. **Eligibility:** Clinical Training Summer School is open to students who have completed at least their third year and are in good academic standing. 2. **Duration:** The program spans four weeks, with students rotating through different specialties. 3. **Supervision:** Each student will be supervised by designated clinical preceptors who are specialists in their respective fields. 4. **Assessment:** Students will be evaluated based on their performance in each specialty, adherence to medical protocols, and ability to perform Entrustable Professional Activities (EPAs).

Procedure

Procedure steps	Responsibility
1. Application: 1.1. Applications must be submitted through the registration link provided on the FCMS website. 1.2. Applicants must complete the online form and upload necessary documents, including a personal photo and academic transcript. 1.3. For non-FCMS students, a non-refundable application fee of 2000 SR must be paid upon submission.	**Applicants**
2. **Selection:** 2.1. Priority will be given to students currently enrolled at FCMS. 2.2. Non-FCMS students are eligible to apply and must additionally submit a referral letter from their universities.	**Clinical Training Unit**

2.3. Selection will be based on the completeness of the application and the order in which applications are received.	
3. **Department Coordination:** 3.1. Once a student is selected, FCMS will send a training request along with the student's information to the relevant department to seek acceptance and ensure the department is prepared to integrate the student into the clinical training process.	**Clinical Training Unit**
4. **Orientation:** 4.1. An orientation program will be held prior to the start of rotations to brief students on their responsibilities and the program's structure. 4.2. Attendance in the orientation program is mandatory for all participants.	**Clinical Training Unit**
5. Actively participating, adhering to all clinical protocols, and completing all required documentation and evaluations.	**Students**
6. Provide supervision, education, and timely feedback.	**Clinical Preceptors**
7. Overseeing the program's administration and ensuring compliance with this policy.	**HOD-Clinical Sciences Department & Clinical Training Unit**
8. Review and respond to the training request by confirming the acceptance of assigned students and preparing necessary resources and supervision for the upcoming rotations.	**Clinical Sciences Department & Vice Dean for Clinical Affairs**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-41	
Policy Title: Elective courses	☑ New	☐ Revised
	Version-1 was Prepared on: 30-09-2024	
	Version-2 is Approved on: 09-10-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 09-10-2029	

Statement of the Purpose	1. To define the steps for establishing and guiding the operation of elective courses in the MBBs Program 2. To ensure efficiency, by avoiding duplication of the course learning outcomes with those of other core courses 3. To ensure that students are placed in elective courses in a fair and organized way that recognizes their academic achievements while also balancing course capacities and student preferences. 4. To ensure awareness of students of their choices of elective courses and how this will help them in career decision. 5. To ensure students rediscover their aptitudes and abilities and, based on this, to obtain information necessary for future career decisions 6. To provide opportunities for students to gain experiences not only limited to schools and hospitals. 7. Empower students to pursue their interests, develop essential skills, and prepare for the complexities of modern medical practice, thereby contributing to their overall professional identity formation.
Policy	1. This policy applies to all students eligible for elective courses, faculty members responsible for these courses, and administrative staff involved in course enrollment. 2. Eligibility criteria 2.1. Student Eligibility: All students reaching the fourth year are eligible to enroll in elective courses, provided they meet any specific course prerequisites or GPA (Grade Point Average) requirements set by the department or instructor. 2.2. Course capacity: Each elective course will have a defined maximum number of students it can accommodate by available resources, including faculty and classroom size. 2.3. GPA-based distribution process: The GPA ranking of students will determine the order in which students are placed in their preferred elective courses. 2.4. Priority enrollment: Higher GPA students will be assigned to their first choice while subsequent students will be placed in courses in descending order of GPA.

2.5. Course Preference Submission:

2.5.1. Preference form: Students must submit a list of preferred elective courses in ranked order before the assignment process begins.

2.5.2. All preferences are to be submitted by the predefined deadline. Late submissions are processed after those submitted on time regardless of GPA.

2.6. Course assignment and distribution:

2.6.1. Students are notified of their assigned course via the official communication channels. They will also be provided with any details regarding the start date, location, and required materials.

Procedure

Procedure steps	Responsibility
1. <u>Phase I (Planning Stage):</u> 1.1. Preparation of orientation session for each offered elective course before the beginning of the semester by 3 weeks 1.2. Posting these orientation sessions to students to increase their awareness of each course 1.3. Define course capacity and requirements **2. <u>Phase II (Implementation Stage):</u>** 2.1. Collect and organize data as follows: • Gather student information (GPA and preferences for elective courses) • Create a spreadsheet: Organize this data in a spreadsheet with columns for Student name, GPA, Course Preferences, and assigned course 2.2. Rank students by GPA: • Sort by GPA: rank students from highest to lowest • Create groups: Depending on the number of courses and students, groups are made based on GPA. 2.3. Assign students to courses • High GPA students will be assigned to their first choice. If a course reaches its capacity, move to the student's next choice.	**Program Director** **Coordinators of elective courses**

- Middle GPA students: After High GPA students are assigned, move to the middle GPA and repeat the process
- Low GPA students: Finally assign low GPA students based on remaining availability

2.4. Adjust for balance and fairness:

- Review assignments: Ensure no course is over or under capacity. Adjust as needed to balance the courses.
- Manual Adjustment: If some students did not get to any of the choices, consider a manual adjustment to accommodate their preferences without exceeding capacities

2.5. Finalize distribution and communicate with students:

- Confirm the final assignment and update the spreadsheet
- Notify students of their assigned elective course and provide any additional instructions.

3. <u>Phase III (Evaluation & Monitoring):</u>

3.1. Gather feedback from students after the first week about their elective courses

3.2. Review how well the GPA-based assignment worked and consider any necessary improvements for future cycles.

3.3. Collect students' feedback by conducting the course evaluation survey and implement improvement plans accordingly.

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-42	
Policy Title: Mentoring Policy	☑ New	☐ Revised
	Version-1 was Prepared on: 04-03-2024	
	Version-2 is Approved on: 02-06-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 02-06-2029	

Statement of the Purpose	1. Prepare mentees during the clerkship phase of MBBS program and guide them to achieve success. 2. Provide mentees with career and non-academic counselling, 3. Guide, support, and counsel mentees s on their upcoming life, health, mental and emotional well-being. Listen to their concerns with patience and assist them in resolving issues by providing appropriate resources, support, and referrals.
Policy	1. All MBBS program students doing the clerkship phase will have an assigned mentor to support them throughout the clerkship period and guide them in achieving their goals. One mentor will be assigned to a maximum of five students during the last four years of their study. 2. The mentoring process is coordinated by the Clinical Training Unit (CTU) and the Clinical Science Department (CSD), which is under the direct supervision of the Vice Dean Clinical Affairs (VDCA). 3. The mentor will remain the same throughout the mentee's mentorship program. The mentor may be changed only with the approval of the HOD in appropriate circumstances. 2. Each mentor will receive 5 students in the mentorship program. A new student will replace any student who ends the formal mentoring relationship for any reason.
Procedure	

Procedure steps	Responsibility
1. **Planning stage:**	
1.1. Conduct orientation and awareness sessions for students (Mentees) about the mentorship.	**CTU** **CSD**
1.2. Conduct Mentorship preparation sessions for faculty staff members (Mentors) about the mentoring process and their roles and responsibilities.	**CTU, CSD, and Medical Education Department**
1.3. Develop a mentorship guide that includes clear roles and	**CTU**

	responsibilities for mentors and mentees.	**CSD**
1.4.	Students fill in a mentor selection form, where they select a list of 3 preferred mentors. One of them is assigned according to availability.	**CTU**
1.5.	The CTU assigns a mentor for each student, with a maximum of 5 mentees per mentor, and organizes an initial meeting during the orientation program.	**CTU**
2.	**Implementation stage:**	
2.1.	The CTU organizes mandatory meetings between mentors and their assigned mentees as follows:	**CTU**
2.2.	Conduct the first meeting during the first week of the academic year and discuss the following: • Explain the goals of the mentorship process and discuss how confidentiality will be maintained. • Talk informally about non-academic matters to keep the mentees relaxed. • Review the mentee's current experience and qualifications. • Ask the mentees to self-assess his or her strengths and areas for improvement. • Ask the mentees to discuss any concerns they might wish to disclose. • Discuss the mentee's immediate and long-term goals. • Discuss the expectations during the clerkship period. • Discuss the mentee's career plan. • Arrange a monthly meeting schedule. • Fill in the mentee's health and social status follow-up in the 1st week of each semester. • The forms should be submitted to CTU to make a database for mentees who need psychological support, financial support, etc. Also, mentees who have various	**Mentors and mentees**

	talents and different hobbies are identified and provided support and guidance accordingly.	
2.3.	Individual meetings are held on a monthly basis throughout the semester as directed by the VDCA.	**Mentors and mentees**
2.4.	Within 3 months, after 3 meetings, both the mentor and mentee will be asked separately if they would like to continue or stop the mentorship. In this case, another mentor will be assigned to the mentee.	**CTU**
2.5.	As needed, additional meetings can be organized between the mentors and the assigned mentees, and this should be documented.	**Mentors and mentees**
2.6.	Mentors follow up with their mentees regarding any difficulties, developmental plans, and career-related activities, including reflection.	**Mentors and mentees**
2.7.	If the mentee faces any problem that affects his/her career or non-academic life, the mentor guides the mentee to helpful materials (including reading certain books, attending certain activities, or referring the mentee to the SSS to help students based on his/her needs (financial, social, health, academic support, etc.).	**Mentors and mentees**
2.8.	The CSD monitors the implementation of the mentorship process, the progress of the mentees, and the support given.	**Head of Clinical Sciences Department**
3. **Evaluation phase**		
3.1.	Student satisfaction survey on the mentorship process is conducted at the end of the academic year by the Quality and Accreditation Unit (QAU).	**QAU**

	3.2. Faculty staff members' satisfaction with the mentorship process is conducted at the end of the academic year by the QAU.	**QAU**
	3.3. The CSD submits an annual report to the Dean.	**QAU**
	3.4. Internal Quality Assurance System (IQAS) monitors compliance with this policy and procedures.	**QAU**

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-43	
Policy Title: MBBS Student Assessment Policy	☐ New	☐ Revised
	Version-1 was Prepared on: 01-08-2017	
	Version-2 is Approved on: 01-08-2022	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 01-08-2027	

Statement of the Purpose	1. To define the rules and regulations of students' assessment for MBBS program. 2. To ensure that the student assessment process is in compliance with MOE regulations. 3. To confirm that students' achievement verification practices followed at MBBS.
Policy	This policy and its associated procedures apply to all students and staff enrolled in or involved in the delivery of undergraduate courses. It sets out the principles that underpin the MBBS program approach to assessment and the mandatory procedures for the implementation of assessment. 1. **Assessment Principles:** Assessment must be designed to contribute to high quality student learning and underpin the development, delivery, and quality assurance of courses. Assessment should both help students learn (learning by assessment) and measure explicit evidence of their learning (assessment of learning). Assessment: a. Must be standards-based and provides evidence of the level of achievement with respect to learning outcomes and graduate attributes. b. Must be a transparent process carried out with honesty, integrity, and confidentiality in line with the Mission of the college. c. Must comprise a variety of tasks which are reasonably achievable by students; and must be fair, inclusive, and equitable for all students. 2.**Types of assessment** 2.1. **Formative Assessment:** It is the part of the assessment process which evaluates ongoing teaching/learning process throughout the course. Ongoing feedback provides the student with the opportunity to enhance their performance. Specific recommendations from the course coordinator and academic advisor on strategies for improving student performance will be helpful and should be documented (refer to Formative assessment policy LAT-31). 2.2. **Summative assessment:** 2.2.1. Summative evaluation provides a graded assessment of student

learning at regular intervals of the course, the grade counts toward the final grade.

2.2.2. Summative evaluation tasks are graded and weighted based on the course's grading scheme as described in the course specification.

3. **Forms of Assessment**

Forms of Assessment may include:

3.1. **Written Exam**: It may take different form of questions such as: short answer questions, multiple-choice questions, and essays.

3.2. **Written Assignments**: It may take the form of essays, reports, case studies and portfolios.

3.3. **Presentations**: These are conducted within group discussion. In these presentations, the students will be delegated particular topics for research and will be required to present their findings.

3.4. **Practical exam** Skills lab exams (Objective Structured Practical examination OSPE) and clinical exam (Objective structured Clinical Examination OSCE) students may be required to complete a series of practical clinical exams designed to assess students' abilities under 'real world' conditions.

3.5. Objective Structured Clinical Examination (OSCE) is applied for MBBS students to assess the students' clinical skills. The construction of stations and blueprint follows policy and procedures of OSCE (Refer to OSCE Policy: LAT-32).

3.6. MBBS Program applied clinical portfolio as a part of continuous assessment (refer to Students' Portfolio for Undergraduate Medical Education Policy LAT-01). The components of clinical portfolios include (Case-based discussion, DOPS, Mini-CEX, Evidence based assignment, reflection and others).

Procedure

Procedure steps	Responsibility
1. Student Notification of the Form of Assessment During the first week of semester, Students will be provided with a description of the means of evaluation to be used in the Course which l includes: 1.1. Course Learning outcomes with assessment methods and score distribution 1.2. Course activities 1.3. The evaluation tools 1.4. The date, time, and location of their	

	Assessment tasks	
	2. Rules and Regulations:	
	2.1. All teaching staff (course coordinators and clinical instructors) should attend the training session for student assessment annually. 2.2. A student must attempt all assessment items mentioned in the course specification. 2.3. Faculty members are expected to treat students fairly and honestly in the evaluation of their academic performance. 2.4. In each course, students are provided with two or more assessment tasks per course (Midterm and Final exams), quizzes, oral presentation or assignments or any assessment methods relevant to learning outcomes mentioned and graded in the course specification. 2.5. The student performance: All semester activities should be evaluated by oral presentation, skills lab demonstration, clinical exam (if applicable), quiz and other class tasks, or all of these or some of them, together with mid a final written exam. 2.6. Student's semester activity assessment is done via using relevant assessment rubric form. (Attached).	
	2.7. The total of marks for each course must be 100% divided into midterm exams, semester activity and final exams. 2.8. A minimum/pass mark in all courses is 50% for each theoretical component, 50% for each practical component and 60% in clinical component. 2.9. Students must achieve a minimum of 50% separately in each theoretical assessment component, namely Paper 1, Paper 2, and Paper 3, for all courses, as outlined in the approved assessment plan in Annex 1.	

		2.10. Student who goes through reset in any of the three components (theoretical, practical, or clinical) will be deprived from the continuous assessment grade and shall only receive 60% as a maximum total grade. 2.11. Course coordinator should change the contexts and questions of assessment tasks from semester to semester to prevent copying of earlier students' work. 2.12. All examinations must be taken within the schedules that are announced by the Examination Committee. 2.13. The course coordinator submits the sealed exam questions to the Head of Department (Set-1 & Set-2, with key answer and course blueprint) at least 10 days before the scheduled date of examination. 2.14. Marking and auditing exam papers should be conducted in the control room to ensure the confidentiality of exam papers. 2.15. Course coordinator should mark exam papers and registers the marks achieved by the students in the result sheets prepared for that purpose. 2.16. Course coordinator should sign the result sheet and approve it from the Head of the Department, and then enter results in the college website.	
		2.17. The student is not allowed to take more than two exams for different courses in the same day. 2.18. The students are not allowed to enter any examination after half an hour of the exam time and will not be allowed to leave before half time of the exam. 2.19. a student is absent for an assessment the Head of the Department may allow the student to undertake the exam if the student produces approved sick leave or provides some other evidence for the absence, and if the reason for the absence is acceptable to the Head of the Department. 2.20. Course coordinators must submit the	

blueprint (refer to Blueprint Policy LAT-21) and exam matrix with student result to ensure the reliability and accuracy of students and confirming the standard of student's achievements of learning outcomes.

2.21. Course coordinators plan for the implementation of clinical portfolios.

2.22. The assessment center members with the course coordinators revise the blueprints of formative exams, Tests, OSPE and OSCE exams.

2.23. The assessment center members with the course coordinators revise questions in tests (refer to MCQs policy LAT-23), checklists, and stations in OSPE and OSCE (refer to OSCE and OSPE policies LAT-32,33).

2.24. Course coordinators develop a question bank classifying the items according to its difficulty and Report of Internal verification of Assessment (refer to Internal verification policy LAT-29).

2.25. Course coordinators give a constructive feedback after

2.26. Formative and summative assessment for their students

3. **Assessment weight and methods of assessment**

3.1. **Assessment weightage distribution:**

Table 1: MBBS assessment plan for Courses without a practical or clinical component – theory only:

Assessment Item	Theory
Formative Assessment	0%
Summative Assessment 1.1 Midterm Written Examination	20%
1.2 Final Written Examination	40%
Continuous Assessment (40%) 2.1 Quizzes X2	10%
2.2 Semester Activities (assignments, research activities, community activities and presentations).	30%
Total	**100%**

Table 2: MBBS assessment plan for Courses with a practical / clinical component:

Assessment Item	Theory	Laboratory
Formative assessment	0%	0%
Summative Assessment 3.2. Midterm Examination	Written 10%	OSPE / OSCE %10)end of module(%20)end of semester(
3.3. Final Examination	20%	
Continuous Assessment Portfolio: Student PPTs 2.5% Integrated cases and Clinical Case presentation: 10% Reflection: 2.5%	40%	
Student activities Observership: 5% Quiz 5% TBL 5% PBL 5% Assignment 5%		
Total	**100%**	

Table 3: MBBS assessment plan for Courses with a practical / clinical component theory and clinical parts (for clinical years)

Assessment Item	Theory	Clinical
Formative assessment	0%	0%
Summative assessment	Written	OSCE
Midterm examination	10%	10%
Final examination	20%	20%
Continuous Assessment Quizzes	5%	Clinical Portfolio 30%
Assignments/ Prsentations/ TBL	5%	
Total 100%	**40%**	**60%**

3.2. Questions distribution and the time allowed to answer each type of question is defined as follows:

	Type	Percentage	Time allowed to answer

			each item
1.	MCQs	60%	1.5 min
2.	EMQs	20%	1.5 min
3.	Short Essay	10%	3 min
4.	Long Essay	10%	min **7**
5.	Modified Essay Questions	Accordin g to the module	12 minutes

Grading Elements:

i. Students are required to achieve a minimum Grade Point Average (GPA) of 2.0 at each level in each course (out of a possible 5.0); if they fail to achieve this level, they do not pass and must retake the course. GPA is determined by dividing the total number of points from all the courses the student has attended by the number of units in the student's schedule.

Cumulative Grade Point:

Cumulative Grade Point Average (GPA)	Grade
Greater than 4.50	Excellent
3.75 < 4.50	Very Good
2.75 < 3.75	Good
2.00 < 2.75	Pass
Less than 2.00	Fail

Grading System:

Grade	Numerical	Average Point
A+	95-100	5.0
A	90-less than 95	4.75
B+	85-less than 90	4.5
B	80-less than 85	4.0
C+	75-less than 80	3.5
C	70-less than 75	3.0
D+	65-less than 70	2.5
D	60-less than 65	2.0
F	Below 60	1.0

ii. Students Graded Auditing

Examination committee is responsible for

auditing the calculation of the student's grades to ensure the accuracy of its calculation.

iii. **Quality Assurance, Verification and Review** Assessment tasks must be subject to routine assessment verification processes and review through consensus verification practices which include:

iv. **Peer review:** MBBS program with Assessment Center will assign faculty staffs to review the examination process in each course to ensure that they reflect appropriate assessment design and grading.

b. **Internal Verification: (refer to internal verification policy)**

c. **External Verification: (refer to external verification policy)** External examiner from other local universities will attend examination procedures and verify students result by using specific checklist.

d. **Communication of Graded to Students** After the approval of the student's result by the College Council, all course coordinators will enter the results in the Peoplesoft to be announced to students after being audited by the Heads of Departments within two weeks.

e. **Student grading appeals:** Students have the right to appeal any action or decision that may affect the ultimate evaluation of their performance in a course. Academic appeals are limited to matters affecting evaluation, {See the MBBS student Appeals Policy and Procedures}.

f. **Assessment Feedback:**

i. Timely feedback to the student throughout the semester is considered an essential component of the teaching and learning process. Feedback will be provided by a variety

of methods including discussions in lectures and tutorials, review of individual marked coursework and review of marked examination papers on request.

ii. Review of assessments by student

iii. A request for a review must be made in writing and lodged with the relevant course coordinator within three working days of formal notification of the grade.

iv. The grounds upon which the student may request a review of a grade are that the student believes that:

v. An error has occurred in the calculation of the mark

vi. The grade is inconsistent with the assessment requirements or assessment criteria.

vii. The Examination Committee will normally respond to the request for a review of a grade in writing within ten working days and may confirm or vary the original decision.

g. Dealing with cheating

The student who cheats or attempts to cheat in the exam or violates the rules and regulations of conducting the exam is punished as per the rules of disciplining students issued by the College Council. (Refer to MBBS student examination cheating policy No-).

Examiner Conflict of Interest

The Assessment Center will take all reasonable steps to

ensure that no conflict of interest that relates to its operations has an adverse effect. When this does happen, the Assessment Center will take all reasonable steps to mitigate the adverse effect as far as possible and correct it. (Refer to conflict of interest policy- No-)

i. Special Consideration:

		i. Reasonable Accommodation of Students: 1. Special provision may be made in cases of disability, long and short-term illness, chronic and temporary illness or other major disruptions to study which affect a student's ability to attend an assessment task. 2. Examination committee will arrange for special provisions may include extension of submission date of assignment, special examination arrangements, deferred examinations, or other special adjustments. 3. Applications for special provisions must be made using the prescribed form and include any required supporting evidence in accordance with the Assessment Procedures. Refer to Examination process policy (Attachment No- 1) for further details. 4. Students who didn't attend the assessment without a documented excuse will receive a grade zero (0) for the Assessment. **ii.** Field practice assessment (The Internship Year): 1. Assessment of students in field practice includes formative and summative evaluation according to the following assessment process. A. The field supervisors should submit biweekly report regarding the students' performance based on required learning outcomes this report should be discussed and signed by student. (Refer to the internship process policy-No). B. Students will conduct case-based discussion evaluated by the faculty staff. C. At the end of each unit rotation the faculty member with field staff will evaluate the student	

	by using rubric intern student assessment form, if student hasn't achieved a satisfactory report, he/she should repeat the practice period in that unit. D. No grade of student will be achieved by the end of internship training period (only Pass or Not Pass).	

Fakeeh College for Medical Sciences	Policy Number: LAT-MBBS-44	
Policy Title: Program Learning outcomes approval, review and monitoring	☐ New	☑ Revised
	Version-1 was Prepared on: 22-7-2019	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. To establish a structured and systematic process for the development, approval, periodic review, and continuous monitoring of Program Learning Outcomes (PLOs). The policy ensures that PLOs are clearly defined, measurable, and aligned with the program mission, institutional goals, graduate attributes and relevant national and international academic and professional standards. 2. To ensure that Program Learning Outcomes remain current, relevant, and responsive to advancements in the medical discipline, labor market needs, and stakeholder expectations, including students, employers, and accrediting bodies. 3. To support the use of evidence-based evaluation and continuous quality improvement processes, ensuring that PLOs are effectively achieved and contribute to the development of competent graduates with the required knowledge, skills, and professional attributes.
Policy	1. The MBBS program must define clearly articulated and SMART PLOs that are aligned with: • Program mission and goals • Institutional graduate attributes • National qualifications frameworks and accreditation standards covering all the three domains of learning. • Specialized academic standards 2. PLOs must be approved by the MBBS Program Steering Committee, Institutional Curriculum Review and Monitoring Committee (ICRMC) and College Council**.** 3. PLOs must be periodically reviewed (annually) and updated based on evidence and stakeholders' feedback. (mainly students satisfaction and advisory committee). 4. MBBS Program implement monitoring mechanisms to assess the achievement of PLOs.
Procedure	

Procedure steps	Responsibility
1. Development of PLOs The Development of the PLO is informed by the National Qualification Framework (NQF), Specialized Academic Standards (SAS), stakeholder involvement and	

	national and international benchmarking (GMC graduate outcomes) through the following steps:	
	1.1. Review of Program Mission and Goals and ensure that the PLOs are directly reflected and support the program's mission and objectives.	**Curriculum review and Learning outcome Monitoring committee (CRLOMC) Medical Education Department (MED) Program Directors (PD)**
	1.2. Benchmark the PLOs with national and international similar program to ensure competitiveness and alignment with global standards.	**Curriculum review and Learning outcome Monitoring committee (CRLOMC) Medical Education Department (MED) Program Directors (PD)**
	1.3. Review and collect input from different key stakeholders (advisory committee members, employers and others to meet market and societal needs.	**(CRLOMC) (MED) (PD)**
	1.4. Ensure compliance with the NQF and SAS through comprehensive alignment between PLOs and Domain of learning level descriptors and Key Learning Outcome (KLOs).	**CRLOMC MED Program Directors**
	1.5. Feedback from all the previous steps is analyzed to develop measurable PLOs statements through using clear, action-oriented verbs and ensuring each PLO is (SMART), Specific, Measurable, Achievable, Relevant and Timebound.	**CRLOMC MED Program Directors**
	1.6. Finally, PLOs are drafted and internally reviewed for final approval.	**MED CRLOMC MPSC**
	2. **Approval process:**	
	2.1. The Final PLOs are reviewed and approved at the level of MBBS Program Steering Committee (MPSC) to be submitted to Institutional Curriculum Review and Monitoring Committee (ICRMC) for final approval in College Council (CC).	**MPSC ICRMC CC**

	3. **Distribution:**	
	3.1. The students should be oriented on the PLOs during the orientation program and each course/Module orientation. Additionally, they are available in each course/Module study guide.	**Program Directors Module/course coordinators**
	3.2. Program handbook- in Arabic and English versions- is distributed to all students, which includes information about the PLOs.	**Program Directors**
	4. **Periodical Review process:**	
	4.1. PLOs are internally and externally reviewed annually to consider the following: • minor changes occurred in the curriculum (If any). • The PLOs achievement • All key stakeholders feedback and • External Benchmarking.	**Program Directors**
	4.2. The program, including the PLOs, is regularly reviewed periodically every five/seven year as prescribed by "Curriculum Review Policy".	**External Reviewer MPSC ICRMC**
	5. **Monitoring and Evaluation:**	
	5.1. The PLOs mapped to CLOs to ensure appropriate curriculum mapping and improve the monitoring and evaluation process.	**CRLOMC MED**
	5.2. Each semester the PLOs achievement is calculated through the PLOs-CLOs mapping using direct and indirect assessment methods.	**CRLOMC MED MPSC**
	5.3. Action plan is formulated based on PLOs achievement to be included in Annual Program Report.	**CRLOMC MED MPSC**
	5.4. This action plan is discussed at the level of CRLOMC, MPSC and ICRMC to be followed	**MPSC ICRMC**

	up for closed monitoring and implementation.	
	5.5. Recalculation of PLOs in the next semester to assess the improvement and close the loop of quality assessment.	**MPSC** **ICRMC**
	6. **Continuous improvement**	
	6.1. Any identified gaps in PLOs achievement should lead to one of the following: • Curriculum modification • Teaching and assessment enhancement Faculty development initiatives	**CRLOMC** **MED** **MPSC** **ICRMC**

Students

Fakeeh College for Medical Sciences	Policy Number: STU-MBBS-01	
Policy Title: Admission Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 31-12-2029	

Statement of the Purpose	The purpose of this policy is to provide a guideline for the process of admission for Bachelor of Medicine and Bachelor of Surgery "MBBS" program.
Policy	1. FCMS provides an opportunity for students to continue and complete their education to get a bachelor's degree in medicine and Surgery. 2. All applicants are to follow the admission process according to FCMS and MOE admission requirements. 3. All required documents and conditions must satisfy the admission criteria. Exceptions may apply based on the Dean's directives (General Aptitude Test (GAT) score or Scholastic Achievement Admission Test score). 4. At FCMS, every effort is made to ensure that all qualified applicants are provided with full consideration for admission and does not discriminate in access to MBBS program and activities. 5. All students enrolled in the MBBS program at FCMS must possess the intellectual, ethical, physical, and emotional capabilities required for the professional practice. 6. MBBS management considers reasonable accommodations for otherwise qualified students with special needs as per decision of the medical examination team (from DSFH) as well as the Academic Affairs Committee (AAC) based on the guidelines for practice in the profession.
Procedure	

Procedure steps	Responsibility
1. Applicants shall fill-in "the admission form", "at the Admission Unit (AU) or through College website.	**AU**
2. Applicant should complete applications and all admission forms on time.	**Applicant**
3. Applicant must provide the required documents to AU during the stated period of admission as per the announcement.	**Applicant**

	4. Applicant must pass the College Multiple Mini Interviews (MMI).	**Applicant**
	5. The weighted average formula shall be calculated to rank the students as follow: a. Admission to first year of the program: 40% high school score, 15% General Aptitude Test (GAT) score, 15% Scholastic Achievement Admission Test score, and 30% for the interview totaling 100%. b. Transferred student to second year: 40% high school, 15% General Aptitude Test (GAT) score, 15% Scholastic Achievement Admission Test, and 30% for the interview. c. For **acceptance** into MBBS program the weighted average should be minimum 80%.	**AU**
	6. Applicant should pass the medical checkup and be physically fit as certified through the arrangement with Dr. Soliman Fakeeh Hospital (DSFH)/ staff clinic or from other hospitals.	**Applicant**
	7. Student/Guardian should sign FCMS contract after acceptance in the MBBS Program.	**Applicant/ Gurdian**
	8. Applicants must submit all required original documents to (AU) within one month of confirming admission to FCMS-MBBS Program.	**Applicant**
	9. Vice Dean for Admission and Registration (VDAR) in collaboration with AU- Director is responsible to ensure the completion of student's files within one month of confirming student's admission. Documentation of any missing documents should be written on student's track sheet.	**VDAR**
	10. In exceptional rare cases if the student did not complete his/her file on time: all the comments will be added to the track sheet in his/her file. In addition, the student will be given one semester to complete the file or else the student will not continue to the next semester.	**AU**

	11. If the Dean requested from the student to repeat the General Aptitude Test (GAT) or the Scholastic Achievement Admission test, the student should sign a pledge to repeat the test and submit the upgraded score within one-year duration. a. If the student repeats the test, then the new score will be considered. b. If the student repeats the test and his/her score is below the expectation, a review to his/her score in the program will be evaluated to ensure that his/her academic performance level meets FCMS expectations.	**AU**
	12. If applicant has any condition that can be considered under disability/special need shall be declared during the admission time (refer to Special needs Policy).	**AU**
	13. For international students' admission to MBBS program will follow the same admission requirements applicable and specified under the MBBS program offered at FCMS. In addition to this they must satisfy the following requirements: a. The Certificates & Transcripts of the qualifying examination must be certified by the Saudi Embassy in the country of their study. b. Further these Certificates & Transcripts must be evaluated & certified by the Saudi Ministry of Education. c. All international students seeking admission to MBBS program must be supported by a sponsor which agrees with MOE stipulations and guidelines.	**AU**

Fakeeh College for Medical Sciences	Policy Number: STU-MBBS-02	
Policy Title: Transfer Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 31-12-2029	

Statement of the Purpose	1. To set guidelines for applicants who are studying at FCMS and wish to internally transfer to the MBBS program. 2. To set guidelines for the applicants who are not currently studying at FCMS and wish to be transferred to the MBBS program, coming from other institutions (external).
Policy	1. FCMS provide its current students the opportunity to change their field of specialization, where they can be transferred from another program to MBBS. 2. FCMS provide students, who are not currently FCMS students, the opportunity to join FCMS MBBS program, if officially they can be transferred from the current institutes to FCMS. 3. Students who completed less than 20% of the courses in the program only will be considered for acceptance for transfer. If they exceed more than (20%) in another institution or another program within FCMS will not be considered eligible for transfer. 4. **The equivalency regulations for institution to FCMS-MBBS program include:** 4.1 Courses taught must correspond to the MBBS program. 4.2 A minimum grade of ”C” is required in the courses already taken. 4.3 The course content must be at least 60% matching the equivalent courses in FCMS-MBBS curriculum. 4.4 Approved equalized courses will not be counted for calculating GPA at FCMS. 5. **The equivalency regulations for program to MBBS program at FCMS include:** 5.1 Courses taught must correspond to the specialty of medicine to which the student request to transfer. 5.2 A minimum grade of “C” is required in the courses taken. 5.3 The course content must be at least 60% matching the equivalent courses in FCMS MBBS curriculum. 5.4 The student is entitled to keep his or her transcript as it is until the decision of the transfer taskforce team regarding the transferred courses equivalency. 5.5 The student’s academic record shall include the grades of the courses that were accepted for equivalency. The courses that were not accepted for equivalency the grades shall not be considered or transferred at all and the student is required to enroll for those courses.

5.6 Approved equalized courses will be counted for calculating GPA at FCMS in the MBBS program.

6. **Applicant shall proceed with the transfer as follows;**

6.1 Cash Students:

6.2 Applicant shall sign on his/her final program transfer application.

6.3 Pay the required tuition through FCMS Finance Unit.

6.4 Visit his/ her assigned academic advisor to discuss the curriculum plan.

6.5 **Scholarship students:**

6.5.1 Admission Unit (AU) must notify the sponsor with the applicant's transfer request.

6.5.2 If sponsor approve the applicant's program transfer request, applicant shall sign on his/her final program transfer application.

6.5.3 Visit his/ her assigned academic advisor, in order to discuss his/her curriculum plan.

6.5.4 If the sponsor doesn't agree for the transfer student must be officially notified by the AU.

Procedure

Procedure steps	Responsibility
1. Transfer from a program to MBBS program within FCMS: FCMS students can transfer their specialty and can change between programs as per the following guidelines:	
1.1. Applicant must fill the transfer request form, and then submit it to the AU.	**Student AU**
1.2. The AU submits the transfer requests with the student's transcript to the chair of the task force team concerned with studying the transfer requests.	**AU**
1.3. The task force team consists of the Vice Dean for Academic Affairs (VDAA), senior faculty members and chaired by the program director to which program the student is transferred.	**AU**
1.4. The task force team shall review the request, transcript and recommend the equivalency regulations, and then send it to FCMS Academic Affairs Committee (AAC) for recommendation.	**Task force team**
1.5. The chair of the AAC submits the recommendations to the Dean of the College for final decision.	**AAC**

1.6. The Vice Dean for Admission and Registration (VDAR) shall notify the student about the decision.	**VDAR**
1.7. The decision should be ratified by College Council.	**CC**
2. Transfer from another institute to FCMS: Students can transfer their current institute and can join FCMS programs as per the following guidelines:	
2.1. The student must provide a transfer letter from the other institution as well as an official transcript and clearance letter to ensure he is cleared from the institution and was not involved in any misconduct or behavioral issues.	**Student** **AU**
2.2. Applicant must fill the FCMS transfer request form and attach it with current transcript and submit it to the FCMS AU.	**Student** **AU**
2.3. The AU submits the transfer requests with the student's transcript to the chair of the task force team concerned with studying transfer requests.	**AU**
2.4. The task force team shall review the request, transcript and recommend the equivalency regulations, and then send it to AAC for recommendation.	**AAC**
2.5. The chair of the AAC submits the recommendations to the Dean of the College for final decision.	**AAC**
2.6. The VDAR shall notify the student about the decision.	**VDAR**
2.7. The decision should be ratified by the College Council.	**CC**

Fakeeh College for Medical Sciences	Policy Number: STU-MBBS-03	
Policy Title: Student's exposure to a communicable disease	☐ New	☑ Revised
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 31-12-2029	

Statement of the Purpose	To minimize the risk of exposure to communicable diseases, to prevent spread of disease among students and the community and to have a uniform, planned approach for dealing with students who had exposed to or have communicable diseases. The MBBS faculty will ensure that each student understands and is capable of adhering to the college precautions.
Policy	1. Students are obligated to report any exposure to a communicable disease. 2. Students are obligated to follow the concerned precautions to prevent infection. 3. FCMS and MBBS program are obligated to ensure the provision of a safe environment of education and learning resources. 4. Students are responsible to have up to date immunization. 5. Students shall be screened periodically to prevent any infection.

Procedure

Procedure steps	Responsibility
1. A student who suspects or has a real contact with an individual or patient that would result in the student's exposure to a communicable disease must report such contacts to clinical instructor.	**Student**
2. If student was exposed or was possibly communicable during clinical experience at Dr. Soliman Fakeeh Hospital (DSFH) and any other institution/agencies, the following procedure regarding communicable disease should be followed:	
2.1. The clinical instructor/preceptor will notify the course coordinator.	**Clinical instructor/ preceptor Course Coordinator**

	2.2. Course Coordinator will complete the report of exposure to communicable disease as soon as possible.	**Course Coordinator**
	2.3. Course coordinator has to consult the staff health clinic at DSFH regarding management of case, to verify reporting requirements.	**Course Coordinator**
	2.4. Staff health clinic at DSFH has to inform infection control department if any action needed.	**Staff health clinic-DSFH** **Infection control Unit-DSFH**
	3. Students will be allowed to attend the classes only if they bring official approval from staff health physician.	**Student**
	4. Testing results of the communicable disease should be submitted to the College, and should be repeated at 6 weeks, 3 months, 6 months, and one-year post-exposure. This will be monitored by the Program director.	**Program director**

Fakeeh College for Medical Sciences	Policy Number: STU-MBBS-04	
Policy Title: Student's Medical Welfare Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 31-12-2029	

Statement of the Purpose	1. To ensure MBBS students, who sustain illness and/or injury during their studies, receive emergency health care and fair health care. 2. To prevent the spread of infectious diseases among FCMS students.
Policy	1. MBBS program develops procedures, including the use of the recording injuries requiring First Aid or other medical treatment. 2. MBBS program ensures the block of any infectious diseases to spread or develop epidemic among its student's population.

Procedure

Procedure steps	Responsibility
1. All MBBS students have the right to receive first aid at a local level. First aid facilities are provided to be adequate for the immediate treatment of injuries and illnesses that may arise at the college.	**Faculty/staff members**
2. FCMS is committed to provide the students with a fair health care coverage, during emergency.	**FCMS**
3. Students are responsible of reporting injury/illness to course instructor and MBBS Program Director before it could adversely affect him/her or other colleagues.	**Students**
4. The student must have a private insurance coverage, and submit the copy of the insurance card to Admission Unit to be kept in students' records.	**Admission Unit (AU)**
5. Screening procedures is mandatory and included as part of admission fees at FCMS.	**AU**
6. In case of absence of health insurance (family or personal health insurance), an identification letter	**Student** **AU**

	should be provided to students to have health insurance with DSFH companies upon their own financial responsibility. Then a copy of health insurance card to be kept in student's records.	

Fakeeh College for Medical Sciences	**Policy Number: STU-MBBS-05**	
Policy Title: Student Grievance Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	**To be Reviewed on: 31-12-2029**	

Statement of the Purpose	To provide guidance and procedures for addressing student grievances and complaints in an equitable manner in order to reach fair and appropriate resolution to student complaints in compliance with FCMS and MBBS program standards for the process.
Policy	1. MBBS program students who wish to file a grievance should first attempt to resolve the issue at its source with the instructor or staff member involved. If such a resolution is impossible, the student may pursue the following steps if he/she wishes to file a grievance. There are two grievance tracks: (1) academic grievances, such as grade disputes and academic dishonesty issues; and (2) all other matters, such as schedules, fees, materials, and property.

Procedure

Procedure steps	Responsibility
1. **Grievances:** **A. Academic Grievances:** (Refer to student academic appeal policy). **B. Non-Academic Grievances:** Students wishing to appeal non-academic matters, such as decisions regarding property, scheduling, etc. as a first step confer with the faculty or staff member involved. If no solution, students can approach the Program director.	**Student**
2. If no solution is reached within 5 working days reporting, the student should contact the Dean by submitting the filled grievance form. (See Annex-1).	**Student**
3. The Dean will gather and analyze appropriate information and if necessary, he/she has the option of	**Dean**

	formulating a taskforce team (comprised of at least one faculty member, one student, and one staff member from administration/Student Support Services selected by the Dean) to help evaluate the student's grievance through interviewing parties involved in the grievance and gathering and reviewing materials pertinent to the case. The decision at this stage of grievance will be made by the Dean based on the facts that have been gathered and report submitted by the taskforce team.	
4.	Within five working days after completing the investigation, the Dean will notify the student of his/her decision.	**Dean**
5.	The decision of the Dean will be final.	**Dean**
6.	FCMS Dean will ensure that students are protected against subsequent punitive action or discrimination following consideration of a grievance or appeal.	**Dean**

Fakeeh College for Medical Sciences	Policy Number: STU-MBBS-06	
Policy Title: Student's Reward Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 01-01-2029	

Statement of the Purpose	Student's rewards policy is to motivate the student quality of performance, fostering learning and curiosity. The rewards are granted to students who are found academically motivated to learn, active, smart, and performing exceptional curricular and extracurricular activities. The tasks being rewarded should be challenging enough to maintain students' interests.
Policy	1. Reward is not new in education; it is addressed as a system to work best. It is used to motivate students to better study skills and higher self-confidence, which will lead to changing behavior. MBBS program recognizes and supports significant students who are to exhibit the behavior FCMS wants, whether it's higher grades, increased attendance, academically and clinically quality of performance, through structured reward and recognition procedures.
Procedure	

Procedure steps	Responsibility
1. Thanks & appreciation letters for rewarding students' performance in following cases: 1.1. Mastery of a task, skills, or subjects& showing intelligent performance. 1.2. Indicate a good of ability in approach learning with a mastery-goal. 1.3. Mastering certain skills or demonstrating increased understanding for reaching a particular performance level or outperforming others.	**Program director** **Head of Department** **Vice Dean for Academic Affairs** **Dean**

	1.4. Any participation in extracurricular activities & or community services activities.	

Fakeeh College for Medical Sciences	**Policy Number: STU-MBBS-07**	
Policy Title: Student's Reenrollment Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	**To be Reviewed on: 31-12-2029**	

Statement of the Purpose	To provide a guide for students wishing to reenroll to FCMS to resume MBBS program.
Policy	1. Student who withdraws is eligible to be reenrolled to MBBS program if he/she fulfilled the reenrollment requirements that include: • Being within 2 Academic Years of inactivity, or as a new applicant if more than 2 Academic Years. • The student was not terminated for academic issues. • It is the 1st application for reenrollment. The College Council may, if necessary, make an exception from this

Procedure

Procedure steps	Responsibility
1. Students whose enrollment is inactivated can submit request to reactivate his/ her registration at FCMS according to MOE reenrollment subject No. 19 as the following criteria:	
1.1. Requests for permission to re-enrollment to be submitted to Vice Dean for Admission and Registration (VDAR) within 2 academic years of the inactive enrollment date.	**VDAR** **HOD**

	1.2. VDAR checks the status of the students and submits the form to the concerned Head of Department (HOD). 1.3. The HOD investigates the submitted forms within 3 days through a tripartite committee chaired by himself (The HOD will present all the cases in the upcoming Department Council for briefing). 1.4. The Tripartite committee Chair fills out a form for each case ensuring fulfillment of all data, prepares any needed documents regarding the cases, includes the signed forms in the meeting minutes and submits the signed forms and meeting minutes with the recommendations to the Academic Affairs Committee (AAC). 1.5. The AAC meets within 3 days of receiving the FORMS to study the cases and submits the final recommendations to the CC to take the final decision. 1.6. The re-enrollment decision has to be ratified by Board of Trustees (BOT). 1.7. If the decision for the request was approved by CC and related departments, the reenrollment using same registration number and records are completed.	**AAC** **CC** **BOT**
	2. If student is inactive for more than 2 academic years, a new request can be submitted, without going back to student record. Student is subject to the academic regulations and requirements in effect at the time of registration and assigned with new registration number.	**RU**
	3. Re-enrollment is dependent upon full disclosure of all relevant and up to date developmental, behavioral and academic information.	**Admission & Registration unit**
	4. If the request for reenrollment is rejected, the student has the right to submit an appeal. The CC will refer the case to BOT for final decision.	**CC**
	5. The student is notified of the final decision through VDAR within 5 working days, with a copy of the	**VDAR**

	final decision will be sent to the concerned HOD and MBBS program director	

Fakeeh College for Medical Sciences	**Policy Number: STU-MBBS-08**	
Policy Title: Student's Orientation Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	**To be Reviewed on: 31-12-2029**	

Statement of the Purpose	Orientation to the MBBS program and its courses is designed to assist with the transition of students into an academic setting. The purpose of this policy is to help students to create a clearer focus on the academic requirements, MBBS program regulations and to be familiar with MBBS program services. Information concerning this orientation program will be provided to students following their admission.
Policy	1. MBBS program believe that orientation of the students is an inevitable part of their study in the program.
Procedure	

Procedure steps	Responsibility
1. It is the responsibility of Student Activity Affairs Unit in collaboration with MBBS Program Director and the Medical Education Department (MED) to arrange and conduct the student orientation program.	**Student Activity Affairs Unit** **Program Director** **MED**

2.	Orientation for new students is mandatory for all.	**Student Activity Affairs Unit Program Director**
3.	The faculty/staff members who are sharing in the orientation work hard to address each member's needs and to include everyone in the group discussion.	**The faculty/staff members**
4.	Orientation program includes infographic films and interactive sessions on regulations of the college and academic requirements, various services offered regulations that students must follow during their study in the college and MBBS Program and also a tour to the college facilities.	**Student Activity Affairs Unit Program Director MED**
5.	Students will be given a copy of handbook which includes details of college and program regulations.	**Student Activity Affairs Unit**
6.	Students will be given certain forms to sign, i.e Code of conduct, list of points including student's attendance, bylaws, dress code..etc. and these forms will be kept in each student's file	**Student Activity Affairs Unit**
7.	Student Activity Affairs will submit the forms to the VDAA who will hand it to the VDAR to be filed.	**Student Activity Affairs Unit**
8.	Student Post Orientation Evaluation form is distributed at the end of the orientation program.	**Quality and Accreditation unit**

Fakeeh College for Medical Sciences	Policy Number: STU-MBBS-09	
Policy Title: Student's Absenteeism Policy (Theory, Laboratory & Clinical practice)	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	**To be Reviewed on: 31-12-2029**	

Statement of the Purpose	To upgrade academic and educational process in MBBS Program by committing to achieve regular attendance of our students in classes, laboratory and clinical practice.
Policy	1. Attendance and participation in course activities are essential to student success at MBBS Program. All students are given orientation. 2. Attendance will be monitored on a weekly basis by the course instructor, and the status will be intimated to the concerned Head of Department (HOD), Vice Dean for Academic Affairs (VDAA), Vice Dean for Admission and Registration (VDAR).
Procedure	

Procedure steps	Responsibility
Regulations of absence, acceptance of excuses and re-examination will be implemented as follow:	
1. **Absence:**	
1.1. Students should be expected to attend all lectures, laboratory and clinical practice regularly.	**Students**
1.2. **For theoretical sessions:**	

	1.2.1. Student gets warning letter: in case of 5% absenteeism of the total number of sessions. Student should sign a written pledge not to be absent again.	**VDAA**
	1.2.2. A student will be deprived from entering the final exam: in case of absenteeism of 10% and above in the theoretical sessions of the course.	**VDAA**
	1.3. **For practical sessions:**	
	1.3.1. Student gets warning letter: in case of 3% absenteeism of the total number of sessions. Student should sign a written pledge not to be absent again.	**VDAA**
	1.3.2. A student will be deprived from entering the final exam: in case of absenteeism of 5% and above in the practical sessions of the course.	**VDAA**
	1.4. **For clinical sessions:**	
	1.4.1. Student gets warning letter: in case of 3% absenteeism of the total number of sessions. Student should sign a written pledge not to be absent again.	**VDAA**
	1.4.2. A student will be deprived from entering the final exam: in case of absenteeism of 5% and above in the course.	**VDAA**
	1.4.3. Students have to compensate the clinical absences before final clinical examination.	**Program director** **VDAA** **VDCC**
	1.4.4. MBBS Program Steering Committee (MPSC) has the authority to decide on the excuses submitted by the student, and the decision will be ratified by Academic Affair Committee (AAC) and the College Council.	**Program director** **AAC** **CC**
	1.4.5. The VDAA issues warning letter for students and a copy is kept in the student file at the Admission Unit.	**VDAA** **AU**
	1.4.6. If the student receives the warning letter officially and refused to sign within five working days, it will be kept in his/her file. The issuing authority should make a note on this warning letter with the date and signature.	**VDAA**
	2. **Excuses:**	
	2.1. **Medical excuses:**	

	2.1.1. A medical excuse issued by Dr. Soliman Fakeeh Hospital (DSFH) will be accepted.	**VDAA**
	2.1.2. Any medical excuse issued by other medical sector must be approved by the staff health physician in DSFH.	**VDAA**
	2.1.3. Students need to submit the original copy of the medical excuse to the MBBS Program director and concerned Head of Department for approval.	**Students** **Program director** **VDAA**
	2.1.4. The medical excuse (Sick leave) will be submitted to the Students' Activity Affair Unit within 72 hours of its release to be discussed in the AAC meeting then it should be kept in the concerned student's file, and a copy must be submitted to the course instructor.	**Students' activity affair Unit** **AU**
	2.2. **Other excuses:**	
	2.2.1. Other excuses (such as a report of death-accidents, etc.) are accepted after validation.	**Students' activity affair Unit**
	2.2.2. The original copy of the excuse must be submitted to the students' activity affair Unit within 72 hours of its release, and a copy must be submitted to the Course instructor.	**Students' activity affair Unit**
	3. **Students' absenteeism for health reasons and return to study:**	
	3.1. If a student is absent for health reasons for a short period of time (maximum 2 weeks) with accepted medical excuse, they can continue their study in the program.	**Program Director**
	3.2. Student has to coordinate with program director and concerned course coordinators and compensate all the absent sessions of the theoretical, laboratory or clinical component of the courses to be eligible to appear for the final examination.	**Program Director**
	4. **Final Exams:** A make-up final exam will be conducted for absent students after submitting acceptable excuses to Examination Committee.	**Examination Committee**
	5. The decision about the other cases which are not mentioned by the pervious instructions will be taken by the MPSC, Academic Affair Committee, then the College Council members.	**MPSC** **AAC** **College Council**

	6. Announcement on the College Screens or Monitors: The announcement of warnings, denial, scheduling of makeup exams or all of the terms-on the college screens is considered to be formal notification to all concerned students.	

Fakeeh College for Medical Sciences	**Policy Number: STU-MBBS-10**	
Policy Title: Extracurricular Activities Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	**To be Reviewed on: 31-12-2029**	

Statement of the Purpose	1. To provide a clear understanding of the role of extracurricular activities in the MBBS Program and to follow a consistent approach in planning and implementation of the activities. 2. To develop and encourage experience and expertise in areas not included in the formal curriculum. 3. To encourage students' active participation in a variety of extracurricular activities. 4. To enhance the reputation of MBBS Program in the community by collaborating with the Community Service Unit to avoid any duplication of activities fostering team work.
Policy	1. MBBS Program considers student involvement in extracurricular activities an inevitable part of the Program educational process. 2. The policy promotes academic excellence of the students by encouraging participation in the extracurricular activities.
Procedure	

	Procedure steps	Responsibility
1.	The Student Activity Affairs Unit (SAAU) prepares extracurricular activities plan; a brief outline of the activities is announced in the orientation day.	**SAAU**
2.	The plan is divided into three semesters, approval of the plan from the MBBS program director, the Vice Dean of Academic Affairs (VDAA) and the College's Dean.	**VDAA**
3.	Announce the plan through the MBBS program website to be accessible for both staff and students.	**SAAU**
4.	There are seven extracurricular activity clubs; 1. Scientific & Cultural Club 2. Sports & Health Club. 3. Social Club 4. Art Club 5. Religious & Islamic Awareness Club 6. Book club, and Theater Club. Students who would like to participate and be a member of one -or more- of the club have to submit the registration form" to the Student Activity Affairs Unit during the first week of the academic year.	**SAAU**
5.	First meeting of the unit, the staff (the heads of the clubs) will discuss the plan of the semester for extracurricular activities (ECA) and asks students to think about the ECA club which they like to join.	**SAAU**
6.	In the second meeting student list involved in each club is prepared and an election of a leader and vice leader for each club to be a spokesperson for each club.	**SAAU**
7.	In the same meeting the head of the club announce the range of activities plan in each club and ask the student to choose the ones they prefer to participate in during the semester.	**SAAU**
8.	Students who would like to participate in one of the ECA have to register his/her name under this activity.	**SAAU**
9.	The leader agrees on a primary spokesperson for each activity which correspondence, questions and arrangements would be addressed with the head of the club.	**SAAU**

10.	"External speakers" will be arranged as required according to the relevance to topics and will have to sign an "external participation form".	**SAAU**
11.	Arrangements are made to allocate the budget needed for each activity as well as the time plan for it	**SAAU**
12.	Clear rules are established to control who, when, where and how the activity will be presented. These rules guide and assist staff and students in preparing and implementing the activities.	**SAAU**
13.	"Post activity evaluation form' has to be distributed among the attendance (students and staff) after each activity then sent for analysis by the statistician then submitted to the SAAU director and to the VDAA.	**SAAU**
14.	Follow up meetings are arranged to follow the implementation of the activity.	**SAAU**
15.	"Trip permission form"; a written and signed parent approval is required if this ECA is held outside FCMS or DSFH.	**SAAU**
16.	Extracurricular Activity Report is prepared after each activity and submitted to VDAA and Quality and Accreditation Unit, at the end of each semester.	**SAAU**

Fakeeh College for Medical Sciences	Policy Number: STU-MBBS-11	
Policy Title: Tuition Fees Payment Policy (According to Course Enrollment)	☐ New	☑ Revised
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	**To be Reviewed on: 31-12-2029**	

Statement of the Purpose	To inform the students and stakeholders regarding the Fakeeh College for Medical Sciences (FCMS)-MBBS Program regulations on student's fee payment.
Policy	1. FCMS provides its students the methods of fee payment, where students could pay their tuition fees based on the signed agreement between two parties. 2. Students shall pay the full tuition fees at the beginning of the academic year. 3. Students must pay 50% of their full tuition fees by the first week of the first academic semester. The rest 50% fee payment to be completed before start of the second semester. 4. In special cases fee payment schedule can be agreed between two parties (Student guardians and FCMS) based on directions from the Vice Dean for Admission and Registration (VDAR) and the Director of Administration and Finance (DAF) with final approval by the College Dean. 5. The provision for fees discount shall only be approved by College Dean e.g., 5% fees discount for siblings, or special discount directed by the Chair of Board of Trustees (BOT).

	6. Students will lose the opportunity to progress on the MBBS program, if they have overdue tuition fees payment from the previous academic year or from the previous semester.
Procedure	

Procedure Steps	Responsibility
1. Admission Unit (AU) shall provide students with detailed information about MBBS program's tuition fees according to the contract they sign at the beginning of the enrolment to FCMS.	**AU**
2. **Tuition payment methods:**	
2.1. **Cash students:** 2.1.1. They will pay the tuition fees directly to FCMS accountant, deposited on the college's bank account or their specified IBANs. 2.1.2. Every student who pays fees will receive an invoice from the accountant. 2.1.3. Any delay in tuition payment could lead to hindering the students' progression throughout the MBBS program. 2.1.4. Students wish to withdraw from the MBBS program must pay all pending fees, in order to make the withdrawal effective.	**Finance Unit** **Registration Unit (RU)**
2.2. **Ministry of Education (MOE) Scholarships:** 2.2.1. Students who have a MOE scholarship, their fees will be covered. 2.2.2. The tuition fees of students who have MOE scholarship will be deposited directly to the College's bank account.	**Finance Unit** **AU**
2.3. **HRDF (Human Recourses Development Funds):** According to the contract between the applicant, FCMS and HRDF.	**Finance Unit** **AU**
2.4. **Other students' scholarship program:** The applicant, who obtains a scholarship from other than MOE and HRDF, must provide FCMS with a financial guarantee letter signed and sealed by the granter.	**Student**

	3. **Additional fees and payments:** 3.1. Medical screening and vaccination fees upon admission (1500 SAR). 3.2. The registration fees for newly enrolled students will be non-refundable 5000 SAR (1000 SAR is for the application fees and 4000 SAR for seat reservation fees). 3.3. Lost student's ID card: The Student will sign "Receiving Student ID Card Form" and if the ID card is lost or damaged by the student, he/she must pay (100 SAR). 3.4. Lost student's graduation transcript (500 SAR). 3.5. Lost student's graduation certificate (1000 SAR). 3.6. Each student will receive a locker for free once they join FCMS-MBBS Program. 3.7. The Student will sign the "Receiving Student Locker Key Form". 3.8. If the Locker Key is lost or damaged by the student, he/she must pay (500 SR). 3.9. Student is also responsible to return back the "Locker Key" to the Student Activity Affairs Unit upon Graduation. Students' Affairs will be responsible to follow up for this matter.	**AU** **RU** **Student Activity Affairs Unit**
	4. **Cycle of cash payment, review and approval** 4.1. **Accountant is responsible to:** • Receive, record and deposit the fee payment from students. • Ensure all received collections are recorded directly on Peoplesoft. • Issue proper electronic receipts through Peoplesoft. • Ensure bank reconciliation is done on timely manner. • All funds collected must be deposited to the authorized FCMS bank account on the same day of collection. If the money received on Thursday this must be deposited in the bank maximum by the following Sunday.	**Accountant** **Finance Unit Manager**

	• Reconcile receipts/deposits with statement of activity.	**DAF**
	4.2. **Finance Unit Manager is responsible to:** • Review the students' payment status and confirm the account balance for each MBBS student after data entry done by the accountant. • Alert MBBS management with students 'overdue tuition fees payment status on timely manner. • Follow up with the students having outstanding balance with a mutually agreed and approved clear timeframe to collect the outstanding dues. • Coordinate with IT to send automatic notification to all students with outstanding balance on timely manner	**DAF and VDAR** **AU and RU**
	4.3. Director of Administration and Finance (DAF) is responsible to further review and approve the transactions through the system. Also notify the MBBS management with students' overdue tuition fees payment status on timely manner. 4.4. DAF discusses strategies to overcome the financial risk due to overdue tuition fees payment in the "Financial planning and Management Committee" and College Dean to come up with a clear timeframe to collect the overdue payment from students. 4.5. DAF in collaboration with VDAR follow up with the students (case by case) having overdue fee payment and take necessary steps to ensure full tuition fees payment without compromising FCMS interests.	
	Admission and Registration Units • Provide MOE with the list of applicants who are eligible for scholarships. • Once applicant receives the scholarship, the Admission Unit will inform FCMS management, financial unit and the applicant.	

	• Provide MOE with the applicant progress. • Update the management and finance unit about any changes on applicant scholarship status	

Fakeeh College for Medical Sciences	**Policy Number: STU-MBBS-12**	
Policy Title: Alumni Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	**To be Reviewed on: 31-12-2029**	

Statement of the Purpose	To provide a common source of data about all alumni students, staff, and stakeholders of the MBBS Program. The anticipated intention behind this mutual resource is to evaluate the improvement in the output of teaching process in the MBBS Program and to build a compassion sturdy society and network.
Policy	1. Alumni policy covers all alumni data, information, records and content which are consistent with laws, rules and regulations created by MBBS program. 2. Student Career and Alumni Unit (SCAU) is responsible for organizing activities and events and will be managed through the office of Vice Dean for Admission and Registration (VDAR). 3. Ultimate open and free membership of all graduates (current and past students) of MBBS program are intended to enroll as members of the MBBS program Alumni and will be maintained through documented contact details. 4. The Alumni which belong to the SCAU will be dynamic, member-focused, and a reflection of Saudi values and customs. Moreover, it is directed towards supporting the social, intellectual, and spiritual needs of all present and future alumni of MBBS program. 5. Graduation Office (GO) will provide the SCAU with names and details of all graduated students.

6. The SCAU will contact all graduated students and invite them to register in the Alumni.
7. Students in the internship year will be encouraged to register in the Alumni.
8. Webpage for the Alumni will be generated as integrated with the FCMS webpage. Online account will be given for each member that includes the followings windows (icons):

    - Updating member's details.
    - Communication preference.
    - Journal access.
    - Email services.
    - Meeting friends.
    - Upcoming events.
    - Photo gallery.
    - Subscriptions for the FCMS services.

9. Information Privacy:
    - The aim of information privacy is to protect the alumni from unauthorized access to members' personal information.
    - The SCAU maintains a database of biographical information about its alumni, including the following:
    - Name, address, National/International ID, telephone numbers and/or email address.
    - Degree(s) and date of degree(s) awarded by MBBS program.
10. Alumni records and databases are only available to academic and administrative offices of the FCMS which might use them effectively according to their duties and responsibilities.
11. Information about alumni should be kept secure and mustn't be shared by third party outside the FCMS except for very limited circumstances after obtaining permission of the FCMS Dean’s office.
12. The Alumni member has the right to withdraw from the membership without giving reasons through his/her account or by a direct request to the SCAU.
13. The SCAU may produce printed alumni directories or provide online instructions freely accessed by alumni.
14. The FCMS has the right to decline online access to any member who misuses the website in a nonprofessional way and to delete user accounts or inappropriate updates to the individual profiles.

Procedure

Procedure steps	Responsibility
1. By the end of each academic year, SCAU will contact the GO to obtain the general	**SCAU** **GO**

	academic and personal details of graduate students.	
2.	Representatives in the SCAU will verbally contact the graduate student.	**Representatives in SCAU**
3.	Developing an alumni analysis sheet to appropriately entering the collected data from the graduates.	**Representatives in SCAU**
4.	Conduct an Alumni survey among Alumni members by the SCAU representatives.	**Quality and Accreditation Unit (QAU) Representatives in the SCAU**
5.	Identify employers of FCMS-MBBS graduates and conduct 'Employers' satisfaction survey'.	**QAU SCAU**
6.	Surveys are analyzed by the SCAU representatives.	**Representatives in the SCAU**
7.	Summarize the main findings of the surveys with suggestions and recommendations for improvement.	**SCAU**
8.	The SCAU will submit an annual report to VDAR, Dean, and the Quality and Accreditation Unit for approval.	**SCAU**

Fakeeh College for Medical Sciences	Policy Number: STU-MBBS-13	
Policy Title: Career Counseling Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 27-09-2017	
	Version-2 is Approved on: 01-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 31-12-2029	

Statement of the Purpose	To provide details regarding MBBS students with career guidance and counseling services offered within FCMS.
Policy	1. MBBS Program intend to provide their students with career counseling services to respond appropriately to the demands and expectations of the community. 2. All students in the MBBS Program are invited and encouraged to constantly meet with career counselors assigned by the Student Career and Alumni Unit (SCAU). 3. Equal opportunities should be available for all MBBS students to meet counselors for facilitating a greeter self-awareness of students in relating to workplace and for exploring and achieving their career goals. 4. Because career development is a continuous process, all students' levels are encouraged to be involved with counseling services. 5. Career counseling members must hold a master's degree or higher degrees (preferably PhD holders) and required to be experts in counseling skills, assessment and evaluation of students' abilities, skills, and interests, and in career information resources.

6. Career counseling members are responsible to maintain confidentiality of student information, including written records and reports.
7. It is the responsibilities of MBBS program' students to develop their professional levels and to comply with career counselors' recommendations, including the follow up if needed.
8. Career counseling members typically offer such services as advising, workshops, events, providing resources of information about job and occupations (e.g. internet resources) and assisting with teaching job search strategies (e.g. writing a résumé and cover letter, learning interview and communication skills, preparing for the SCFHS exams, and learning ways of job searching).
9. The SCAU in the FCMS must facilitate the process of local employers who are interested to recruit students of MBBS program to make their advertisements and to conduct interviews at the campus.
10. The SCAU should provide an appropriate location/office space to conduct career counseling and to carry out its services such as workshops.
11. SCAU is responsible to organize a series of training sessions for its members on career counseling annually.
12. The expected time frame required for the entire career counseling process varies and depends largely upon the workload of the counselors who are faculty staff and have academic duties and lectures.
13. Career counseling for MBBS program students can be performed individually or in groups. If performed in group, it is recommended to include a suitable number of students in each group so that they are comfortable with each other and feel free to participate within the group.

Procedure

The main steps of career counseling procedure for MBBS program students include the following:

Procedure steps	Responsibility
1. Students who find themselves needing career guidance or who are not sure about how their courses relate to their future career and workplace, are welcomed to visit the SCAU.	**Student**
2. Students have to take an appointment by visiting the SCAU.	**Student**
3. The SCAU administrator asks the student (counselee) to fill a form (see Appendix I) asking such data as name, date of birth, academic year level, reason for counseling session, number of visits, counseling session date and time, contact details, etc.	**Student Career and Alumni Unit (SCAU) administrator**

4.	The SCAU administrator checks the availability of counselors with respect to the appointment times given by the student (s).	**SCAU administrator**
5.	Once the appointment time is confirmed by the SCAU, the student has to visit and get career counseling.	**Student**
6.	After completing the counseling visit, the counselor must update the initial form with new details according the results of the counseling session.	**Career counselor**
7.	The SCAU might give the student a new appointment date and time as follow up to evaluate the student's improvement after the counseling visit (if required). This appointment might be determined and confirmed through an email or a text message sent to the student.	**SCAU administrator**
8.	Based on a student's needs for career searching strategies, the SCAU arranges workshops and/or special classes periodically with a minimum of three workshop annually, in particular for senior students fourth, fifth and sixth academic year before graduation.	**SCAU**
9.	The SCAU set a maximum time of 24 hrs. in advance to cancel any appointment. If cancelled in advance, the appointment will be rescheduled within five business days. If the student delayed for more than 10 minutes for an appointment, the career counselor has the right to reschedule the appointment.	**SCAU**

Fakeeh College for Medical Sciences	Policy Number: STU-MBBS-14	
Policy Title: Student Code of Conduct Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 22-1-2024	
Applicable to: MBBS Program	To be Reviewed on: 22-1-2029	

Statement of the Purpose	1. This Code of Conduct contains the policies that relate to the legal and ethical standards of conduct that Fakeeh College for Medical Sciences students are expected to comply with while studying at the college. 2. This policy is intended to help concerned persons focus on areas of ethical risk, provide guidance to help them recognize and deal with ethical issues. It also provides mechanisms to report unethical conduct, and to help foster a culture of honesty and accountability.
Policy	1. The Code of Conduct complements, but does not replace, the standards of behavior and performance required by the college regulations. 2. The code of conduct clarifies the standards of behavior that are expected of students in the performance of their duties and responsibilities. 3. All MBBS program students shall comply with the laws, rules, and regulations applicable to FCMS. 4. Any student found to have committed or to have attempted to commit the following misconduct is subject to disciplinary actions. 5. Acts of academic dishonesty, including but not limited to the following: Any student found guilty of academic dishonesty may be subject to both academic and disciplinary actions. 5.1. **Cheating**: Copying or attempting to copy from an academic test or examination of another student; using or attempting to use unauthorized

materials, information, notes, study aids or other devices for an academic test, examination or exercise; engaging or attempting to engage the assistance of another individual in misrepresenting the academic performance of a student; or communication information in an unauthorized manner to another person for an academic test, examination or exercise.

5.2. **Fabrication or Falsification**: Falsifying or fabricating any information or citation in any academic exercise, work, speech, research, test or examination. Falsification is the alteration of information, while fabrication is the invention or counterfeiting of information.

5.3. **Plagiarism**: Presenting the work of another as one's own (i.e., without proper acknowledgement of the source) and submitting examination, theses, reports, speeches, drawings, laboratory notes or other academic work in whole or in part as one's own when such work has been prepared by another person or copied from another person. Materials covered by this prohibition include, but are not limited to, text, video, audio, images, photographs, websites, electronic and online materials and other intellectual property.

5.4. **Abuse of Academic Materials**: Destroying, defacing stealing, or making inaccessible library or other academic resource material.

5.5. **Falsifying Grade Reports:** Changing or destroying grades, scores or marking on an examination or in a faculty member's records.

5.6. **Misrepresentation to Avoid Academic Work:** Misrepresentation by fabrication an otherwise justifiable excuse such as illness, injury, accident, etc., in order to avoid or delay timely submission of academic work or to avoid or delay the taking of a test or examination.

5.7. **Other:** MBBS program faculty may prescribe and give students prior notice of additional standards of conduct for academic honesty in a particular course, and violation of any such standard of conduct shall constitute misconduct under this Student Code and the College Disciplinary procedures.

6. Violence: A student shall not engage nor attempt to engage in any act of violence against oneself or another person.
7. Weapons, Dangerous Instruments, and Explosive Chemicals or Devices: The possession, use or threat of use of any object that may reasonably be believed to cause physical injury to another person is prohibited.
8. Student Organizations: Student organizations are expected to adhere to the same standards of conduct applicable to individual students.
9. Theft:

9.1. Theft is defined as taking or possessing the property of another without right or permission. Students shall respect the property of the college, its guests, and all members of the college community.

9.2. The unauthorized taking, misappropriation, possession, retention, or disposal of any property owned or maintained by the college, another student, a person attending a college event, or any other person; will lead to disciplinary action.

10. Other malpractice like:
    - 10.1. Furnishing false information to any college official, faculty member, or office.
    - 10.2. Forgery, alteration, or misuse of any college document, record, or instrument of identification.
    - 10.3. Disruption or obstruction of teaching, research, administration, disciplinary, proceedings, and other college activities on or off-campus, including its public service functions on or off-campus, or of other authorized activities.
    - 10.4. Physical abuse, verbal abuse, threats, intimidation, harassment, coercion, and/or other conduct that threatens or unreasonably endangers the mental or physical health, safety or reputation of any person or oneself, including any such conduct achieved through means of social media or any other means of electronic communication.
    - 10.5. Attempted or actual theft of and/or damage to property of the college or property of a member of the college on or off campus.
    - 10.6. Failure to comply with direction of college officials will invite disciplinary action.
    - 10.7. Unauthorized possession, duplication or use of keys and/or keycards to any college premises or unauthorized entry to or use of college premises.
    - 10.8. Use, possession, or distribution of marijuana, heroin, narcotics, or other controlled substances, or drugs against the law of the country.

Procedure

Procedure steps	Responsibility
1. All new students are required to sign a copy of student's code of conduct upon joining. The signed copy of the same is kept in the students' file. (See attachment: 1)	**Student and Students' Activity Affair Unit**
2. Code of conduct must be included as part of the student's orientation program and they need to sign the code of conduct form.	**Vice Dean for academic affairs (VDAA)**
3. An electronic copy of the code shall be present on college website, accessible to all students. Publish the code for students on all visible areas in both English and Arabic language for easy access and viewing.	**Vice Dean for Development and Quality Management (VDDQM)**

	4.	It is the responsibility of MBBS program directors to monitor compliance with the Code of Conduct and to initiate disciplinary action against students who do not abide by the tenets of the Code.	**Heads of Departments (HoD) and Program Director (PD)**
	5.	Academic dishonesty by student:	
	6.	In case of act of academic dishonesty, the faculty member may impose an academic sanction as severe as giving the student a failing grade in the course as per policy and can report the case to the VDAA to be discussed in the "Students' disciplinary committee".	**Course coordinator VDAA**
	7.	Before imposing an academic sanction, the faculty member shall first attempt to discuss the matter with the student. If deemed necessary by either the faculty member or the student, the matter may be brought to the attention of the student's academic adviser, the HOD or the Dean of the college.	**Faculty members**
	8.	When academic sanction is imposed which causes the student to receive a lowered course grade, the faculty member shall make a report in writing of the facts of the case and the academic sanction imposed against the student to the faculty member's HOD and to the Disciplinary Committee chairperson. The student shall be provided with a copy of this report. Further, the faculty member may recommend the disciplinary proceedings against the student for violation of the Student Code, if the faculty member in the exercise of his or her professional judgment believes that such action is warranted.	**Faculty members**
	9.	In cases where a faculty member's finding of academic dishonesty is admitted by the student and an academic sanction is imposed , which the student believes to be too severe, the student shall have the right to appeal the severity of the academic sanction through the applicable appeal procedure.	**Student**

	10. In case where a faculty member's finding of academic dishonesty is disputed by the student, the matter shall be referred to the Academic Integrity and Appeal Committee (AIAC) for disposition in accordance with the college Disciplinary Procedures. Any academic sanction imposed shall be held in pending for a final decision under the college Disciplinary Procedures.	**VDAA**
	11. If it is determined through these procedures that the student did not commit academic dishonesty, the academic sanction shall be set aside. If it is determined that the student committed academic dishonesty, the academic sanction shall be imposed in addition to any disciplinary sanction which may be imposed under the college Disciplinary procedure.	**VDAA**

Faculty

Fakeeh College for Medical Sciences	Policy Number: FAC-MBBS-01	
Policy Title: MBBS Staff Performance Evaluation	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	To establish clearly defined objective parameters for evaluation of MBBS staff performance at Fakeeh College for Medical Sciences (FCMS).
Policy	1. Each MBBS program employee's performance is subjected to periodic review and appraisal through summative and formative evaluation by the program director to provide feedback on the position's key areas of responsibility as set forth in the employee's job description. 2. A new employee has a 90-day probation period and is due for a probation period appraisal at least 30 days before end of probation period. 3. Annual performance evaluations shall occur at least 45 days before the anniversary date of the employee's official date of employment. If the employee's job has changed then the performance evaluation is also due 45 days before the anniversary date of the job change. 4. In alignment with FCMS mission dimensions, the Academic staff performance will be evaluated according to their contribution in the following major sections: 4.1. **Teaching and academic activities: Contribute around 50% to the overall evaluation:** ✓ Course teaching (Theory, Lab& Clinical), Course coordination

	✓ Development of course teaching materials and reports ✓ Participation in professional and academic development programs ✓ Mentoring and advisory activities ✓ Student assessment and evaluation process ✓ Staying current with literature and changing practices in the field of specialty 4.2. **Scientific Research and Scholarship Activities: Contribute around 15% to the overall evaluation** ✓ Conduct research with colleagues. ✓ Conduct research with Students. ✓ Presents abstract in scientific meetings ✓ Publishes papers in ISI journals. 4.3. **Community Engagement activities: Contribute around 15% to the overall evaluation** ✓ Contribute to the development of community engagement plan. ✓ Contribute to the development of community education program. ✓ Participate in community engagement and education activities. ✓ Engages in activities that enhance public image of the profession. ✓ Membership in professional organizations. 4.4. **Professional/Academic Development Activities: Contribute around 10% to the overall evaluation** ✓ Advances knowledge through participation in academic development activities (internal and external) with clear objectives. (Minimum 20 CME Hrs./Academic Year) ✓ Advances knowledge through participation in professional development activities (internal and external) with clear objectives. (Minimum 20 CME Hrs./Academic Year) 4.5. **Administration Activities: Contribute around 10% to the overall evaluation** ✓ Contributes effectively to committees or task force teams. ✓ Contributes to departmental assignments and other quality improvement initiatives. 5. At the end of each academic year, every faculty staff member should submit an academic staff portfolio that includes all their achievements. This portfolio will be used as a guide for an objective annual evaluation. 6. It is the responsibility of Head of Department (HOD) to ensure performance appraisals are conducted and turned back in to HR before the employee's anniversary date. 7. Evaluations for employees on vacation or leave of absence will be postponed until they return to work. 8. The completed Probationary evaluation form for each employee will be part of that employee's official personnel file.

	9. Annual salary increment is applicable for FCMS staff according to their performance regardless of promotion or any other allowance was entitled during the same period. 10. Annual increment is given only for staff members who secured 'Excellent' rating in annual performance evaluation.
Procedure	

Procedure steps	Responsibility
1. **Establishment of Evaluation Criteria**	
1.1. The performance evaluation is based on clearly defined criteria that encompass multiple aspects of academic staff responsibilities. 1.1.1. Teaching and academic activities: Contribute around 50% to the overall evaluation. 1.1.2. Scientific Research and Scholarship Activities: Contribute around 15% to the overall evaluation. 1.1.3. Community Engagement activities: Contribute around 15% to the overall evaluation. 1.1.4. Professional/Academic Development Activities: Contribute around 10% to the overall evaluation. 1.1.5. Administration Activities: Contribute around 10% to the overall evaluation.	**HRU** **Director of Administration and Finance (DAF)** **Quality and Accreditation Unit (QAU)**
2. **Communication of Evaluation Process**	
2.1. The college holds orientation sessions to explain the evaluation process. 2.2. The evaluation process is communicated to all staff through official channels, including faculty meetings, handbooks, and the college's intranet.	**HRU** **Director of Administration and Finance (DAF)** **Staff Development Unit (SDU)**
3. The HRU Officer informs the Head of Departments (HODs)of all the new hires and their hiring date.	**HRU Officer**
4. The HRU Officer prepares the staff lists due for evaluation and forwards them to the HOD.	**HRU Officer**
5. HOD is responsible for developing a system to track deadlines for their employees' appraisals.	**HOD**

	6. **Self-Assessment by Staff Members**	
	Every faculty staff member submits an Academic Staff Portfolio that includes all staff achievements. This portfolio is used as a guide for an objective annual performance appraisal. 6.1. Faculty staff members reflect on their accomplishments, challenges, and professional development activities over the evaluation period.	**Staff member**
	7. The staff member fills out the self-assessment on the performance evaluation form.	**Staff member**
	8. Staff members submit the self-assessment report that highlights their achievements and identifies potential areas for improvement, as well as an academic staff portfolio for the HOD	**Staff member**
	9. **Evaluation by Supervisors** 9.1. HOD should use the concerned staff job description and academic staff portfolio as a reference during the assessment/appraisal process. 9.2. Using the established criteria, HOD provides ratings and comments for each category, identifying strengths and areas for development. 9.3. The HOD will conduct an appraisal interview, complete the probationary/annual performance appraisal form, discuss the points and agree on the final decision, and then return the form to the evaluated employee for their comments and recommendations. 9.4. Staff members will add their comments and prepare an action plan for improvement 9.5. The HOD is responsible for following up and monitoring the achievement of the approved action plan and ensuring staff members' progress.	**HOD** **Staff member** **HOD**
	10. **Feedback from Peers and Students:** Gathering a comprehensive view of the staff member's performance from multiple perspectives (360-Degree Feedback):	**Student**

	10.1. Feedback from students: This includes a teaching staff evaluation survey. The QAU submits the Teaching staff evaluation form to the HRU.	**QAU**
	10.2. Feedback from peers: The college incorporates feedback from peers, which includes an anonymous Staff Performance Evaluation by Peer Form (SPEPF). The form is distributed by the HRU to the identified peers	**Peer** **HRU** **HRU**
	11. **Incorporation of Feedback:** These inputs are reviewed and considered in the final evaluation, ensuring that they reflect a holistic view of the staff member's contributions.	
	12. **Compilation of Evaluation Reports** 12.1. The HRU officer compiles all the documents (performance appraisal form from the HOD or Direct supervisor, Teaching staff evaluation surveys from students, and SPEPF) and submits them to the respective Vice Dean for comments and final review then to College Dean for approval. The approved copy is kept in the employee's personal file, and the staff member receives a copy of the same. 12.2. Each faculty staff member receives a summary report that includes ratings in each category, comments from supervisors, and aggregated feedback from peers and students. The report explicitly outlines strengths and areas where the staff member can improve, providing a clear pathway for future development.	**HRU officer** **Dean** **HRU**
	13. **Professional/Career Development:** 13.1. Based on the evaluation, specific suggestions for career development are made: 13.2. Professional Development Plans: Recommendations may include pursuing further education, attending conferences,	**HOD/ Direct Supervisor**

	engaging in specific training programs, or seeking mentorship opportunities. 13.3. Goal Setting: Faculty staff members are encouraged to set specific goals for the upcoming evaluation period based on feedback received.	**Staff member**
	14. If an employee does not receive a performance appraisal according to the guidelines of this policy, the employee can appeal to the College Dean.	**Staff member**
	15. The IQAS team verifies compliance with the policy, monitors the achievement of the KPIs related to this policy and reports the feedback to QASC.	**IQAS team**
	16. **<u>Related recommendations based on the overall Performance Rating</u>:** 16.1. **At the end of the initial probationary period:** a. If the assessment is deemed satisfactory, the probationary employee will be re-classified as a regular full-time employee. b. If the assessment determines the employee's performance is unsatisfactory, then the employee's HOD will meet with the HRU officer to determine if the employee needs to be released from their employment obligation or reassigned to another probation and assess performance again in another 90 days. 16.2. **<u>Annual Performance Evaluation:</u>** **Excellent Level Rating** - the employee will be included in the annual increment of up to 3% of his/her basic salary if he/she receives an excellent level rating in the performance appraisal rating as per Dean's approval. **a. If the employee's performance is below Satisfactory Level:** 1- The HOD/Director/ Vice Dean must consult with the HRU to decide whether to give the employee a 2nd chance to improve his\her performance	**HR Unit** **HOD** **HR Unit** **HOD/Director/ Vice Dean**

	before the renewal of the contract, or to end his/her contract without giving any 2nd chance. 2- If the employee got "below satisfactory level rating" on the 2ndevaluation, he/she will receive a dismissal letter from FCMS.	

Fakeeh College for Medical Sciences	**Policy Number: FAC-MBBS-02**	
Policy Title: Professional Development Portfolio (PDP) for MBBS academic staff	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	**To be Reviewed on:** 15-01-2029	

Statement of the Purpose	1. To ensure that MBBS program Academic Staff at Fakeeh College for Medical Sciences (FCMS) are continually developing their academic and professional career. 2. To inspire the MBBS program staff to reflect on the work they do. 3. To encourage the MBBS program staff to present tangible evidence for the quality of their work.
Policy	1. At MBBS Program, development portfolio is a means of aligning academic staff activities with criteria set by the college; in addition to those established nationally and internationally. 2. The process of selecting and organizing material for a portfolio help academic staff reflect on and improve their performance. 3. Professional Development Portfolio (PDP) is useful to: 3.1 Document staff's professional development.

3.2 Submit evidence of their areas of strength.
3.3 Identify areas that need further improvement or new skills acquisition.
3.4 Support staff in application for promotion or new jobs.
3.5 Help staff reflect on their experiences.
3.6 Encourage staff to plan for their future.

4. The role that MBBS Program director plays in the process is critical, particularly in the encouragement and guidance of junior staff in developmental posts.

Procedure

Procedure steps	Responsibility
1. Each MBBS program staff member prepares his/her development portfolio for annual review.	**Academic Staff**
2. The development portfolio consists of four sections defined by their purpose at FCMS, including: **Section-I:** Curriculum Vitae **Section-II:** Staff Workload **Section-III:** A summary of Achievements in each of the followings: • **Educational process (Teaching/Assessment).** • **Research** • **Administration and Leadership** • **Student Centered Activities** • **Community (a student activity)** • **Professionalism and Continuous Professional Development (CPD)** **Section-IV: Evidences** A key feature of an Academic Staff Portfolio will be listing evidence of staff performance in support of what he/she may mention. For each of the above-mentioned sectors, relevant evidence is submitted. **Section –V: Reflections** This portfolio is an analytical self-reflection originated to enhance academic staff's performance.	**Academic Staff**
3. **Reviewing Portfolio**	**Academic Staff** **Program director**

	The completed portfolios to be submitted to the MBBS program director two weeks before the scheduled staff evaluation meeting.	
4.	These reviews should take place regularly each year.	
5.	After review and approval by the finalized copy of the portfolios to be forwarded to Human Resource (HR) Unit.	**HR Unit**

Fakeeh College for Medical Sciences	**Policy Number: FAC-MBBS-03**	
Policy Title: Staff Professional Development Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	**To be Reviewed on: 15-01-2029**	

Statement of the Purpose	This policy aims to provide a framework for personal and professional development for all staff members of MBBS program to enhance their growth and development and excel their work performance.
Policy	1. MBBS program is committed to provide the staff with development opportunities to increase and update their knowledge and skills required to enable them to perform their roles efficiently. 2. MBBS program is obligated to provide students with highly qualified, well-trained staff. 3. The professional development activities should contribute to achieving the MBBS program strategic goals.

4. The annual professional development plan must meet the current and future needs of MBBS program, as well as the learning and developmental needs of the academic staff. The plan must be approved by MBBS program director, and the Dean.
5. Staff development activities are included in the job description form for each staff member as a legitimate work activity.
6. All staff should have fair access to staff development activities.

Procedure

	Procedure steps	Responsibility
1.	The Staff Development Unit (SDU) will assess and identify the learning and development needs of the staff in the beginning of each academic year through staff survey, an individual development plan and recommendations of the MBBS program Director.	**SDU**
2.	The SDU will prepare an annual plan for professional activities based upon need assessment per individual (academics and administrative staff) and per department.	**SDU**
3.	The professional development plan for each academic year will be circulated to the Dean, MBBS program Director and MBBS staff via the internal emails for review and suggestions.	**SDU**
4.	The budget plan for the activities will be developed and submitted with the professional development plan to the Dean for approval.	**SDU** **Dean**
5.	The final professional development plan will be submitted for the College Council (CC) for approval, and then it will be circulated to all MBBS staff.	**SDU**
6.	SDU is responsible for the organization, and the announcement of the activity.	**SDU**
7.	A flyer will be developed by the SDU and will be distributed to all staff of MBBS program two weeks before the event.	**SDU**
8.	The planning and implementation of the activities will conducted by the manager of the SDU.	**SDU manager**
9.	Attendance record and documentation for each activity has to be prepared by the planner of the activity, and to be submitted to the Manager of the SDU.	**SDU manager**

10.	At the end of each activity, the staff will provide feedback about the activity using staff development activity evaluation form.	**SDU manager**
11.	Certificates of attendance will be prepared through the SDU within one week after the activity and will be sent to Staff through their respective departments. If CME is obtained for the activity, this will be reflected on the certificate.	**SDU**
12.	The SDU will continuously monitor and evaluate the planned activities, and the Manager will send a report to the Dean, MBBS program Director and the Quality and Accreditation Unit (QAU) each semester.	**SDU manager**
13.	Depending on the outcome and feedback of the report, it may require submission to the College Council and Board of Trustees.	**SDU**
14.	KPIs will be developed to measure the impact of the staff professional development program.	**QAU**
15.	The Media and Public Relation Unit will make an announcement about other activities that are organized by other academic institutions.	**Media and Public Relation Unit**
16.	The SDU will set up rules and regulations for attending professional development activities for MBBS academic staff.	**SDU**
17.	The staff will be encouraged to attend other professional development activities outside FCMS through the following procedure:	**MBBS staff**
	17.1. The themes of the workshop or the conference should be related to the staff's specialty.	**HOD**
	17.2. The devoted staff should submit a request form to the HOD and the details of the activity.	**Dean** **CC**
	17.3. If approved by the HOD, it will be submitted to the Dean for approval.	
	17.4. If the activity is conducted outside the Kingdom, it should be approved by Department Council and College Council.	
	17.5. The devoted staff will be granted scientific leave during the activity period.	
	17.6. If the activity will be conducted outside Jeddah, the devoted staff will be granted a ticket and pocket money for accommodation.	**MBBS staff**

	17.7. After attending the activity, the devoted staff should provide a brief report about the activity and the possibility of implementing this activity in the college to benefit other staff members. 17.8. A copy of the certificate of attendance should be kept in the SDU, and the staff's file in HR Unit.	
	18. The MBBS program director is responsible for ensuring that the staffs are regularly attending FCMS professional development activities and organizing staff attendance of professional development activities in other academic institutions.	**MBBS program director**

Fakeeh College for Medical Sciences	**Policy Number: FAC-MBBS-04**	
Policy Title: Encouraging scholarly and research activities at FCMS	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	**To be Reviewed on: 15-01-2029**	

Statement of the Purpose	1. To encourage the faculty and the students of MBBS program to actively work on research & scholarly activity in order to reach the FCMS academic goals. 2. To ensure that the teaching staff of MBBS program is up to date in scientific research and the staff applies what they gain by relevant scholarly activity and professional practice in a valuable manner.
Policy	1. All scholarly activity associated with the MBBS program must undergo appropriate approval process prior to starting.

2. Teaching staff has to have an up-to-date knowledge of their professional practice and reflect on research and professional activity to facilitate student learning.
3. MBBS program facilitates the education development program in which teaching staff are required to develop scholarly and professional activities.
4. MBBS program adopts a teaching and learning environment in which scholarly and professional activities are promoted and valued, through the provision of working time and resources for teaching staff to achieve agreed scholarly activity.
5. Faculty staff members and students have the chance to attend an international conference/workshop once a year only if they are contributing as speakers and after the approval of their HOD, Vice Dean for Postgraduate Studies and Scientific Research (VDPGSR), and FCMS Dean. This strategy ensures equitable opportunities for all FCMS faculty members and students.
6. MBBS program facilitates research and research collaborations with national and international agencies and institutions.
7. MBBS program encourages staff members to publicize research results through conferences, meetings, and other activities.
8. MBBS program focuses on strengthening education by providing students with training opportunities and access to facilities through engaged research activities.
9. MBBS program is committed to engage in public service programs related to research expertise.
10. Important policies that guide the researcher are:
    - 10.1. Research Intellectual Property Policy
    - 10.2. Institutional Review Board (IRB) Research Governance Policy
    - 10.3. National & International Research Collaboration Policy
    - 10.4. IRB Conflict of Interest
    - 10.5. Publication reward Policy

Procedure

Procedure steps	Responsibility
1. All academic staff members and students must submit their research proposals and scholarly activities to the MBBS Program Scientific Research Committee (SRC) to be approved by their HODs and reported to the Scientific Research Unit (SRU) Director who is going to report to the Institutional Scientific Research Monitoring Committee chaired by Vice Dean for Postgraduate Studies and Scientific Research (VDPGSR).	**Academic staff members** **SRC Chairperson** **HODs** **SRU Director** **VDPGSSR**

2.	The proposal has to be reviewed SRSC and then documented in the corresponding Departmental Council, SRU, VDPGSR to be sent to the Institutional Review Board (IRB).	**SRC** **SRU Director** **HODs** **VDPGSSR** **IRB committee**
3.	The IRB Committee will send the approval letters to the principal investigator's (PI) email of the approved proposals.	**PI** **IRB committee**
4.	The SRU Director and SRC chairperson will be responsible for monitoring the progress and impact made as a result of scholarly activity undertaken to be reported to the VDPGSSR.	**SRU** **SRC** **VDPGSSR**
5.	The Dean may approve leave of absence for academic staff to undertake scholarly activity as per approved policy & procedure.	**Dean**
6.	For the scholarly activities outside FCMS, faculties should submit a form request to the HODs first who may approve it based on their duty's schedules and appropriate delegations. Then, the VDPGSSR may sign the submitted form for the final approval by the Dean who may approve the scientific or business leave submitted by the academic staff to undertake scholarly activity as per approved policy & procedure.	**Faculties** **HODs** **VDPGSSR** **FCMS Dean**
7.	Teaching staff are encouraged to share professional practice with peers and students through groups such as research and group discussion, and professional development activities.	**MBBS staff members**
8.	The impact of scholarly activity on teaching-learning process is evaluated as part of faculty member's performance evaluation and to be incorporated in their teaching materials.	**Heads of Departments**
9.	The knowledge of the faculty members on various aspects of scientific research activities conducted at FCMS-MBBS program is evaluated by means of a survey and awareness sessions are conducted accordingly.	**SRU**

Fakeeh College for Medical Sciences	**Policy Number: FAC-MBBS-05**	
Policy Title: Community Services' Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: FCMS/ MBBS Program	**To be Reviewed on: 15-01-2029**	

Statement of the Purpose	1. This policy provides clear guidance and directions to Bachelor of Medicine and Bachelor of Surgery (MBBS) program at Fakeeh College for Medical Sciences (FCMS) concerning the community services. 2. The policy aims to ensure that MBBS Program is committed to contribute positively to community.

Policy	1. Community service Unit (CSU) prepare community services activities plan annually based on the Saudi community needs through surveys as well as staff and students' feedback. 2. All staff and students of MBBS Program should involve in planning and implementation of community services activities. 3. At FCMS the community engagement activities are conducted in line with its Strategic Community Engagement Plan which is prepared in alignment with the Strategic Plan. 4. CSU submit annual community services activities plan of MBBS Program to College Council for approval. 5. The CSU publishes the approved community services activities calendar to the College Council (CC) for approval. 6. The approved community services activities calendar will be circulated to the staff and students to give them an equal opportunity to select the service activity. 7. Staff and students of MBBS Program will be assigned for each activity. 8. The assigned group of staff and students for each activity is responsible for submitting all the documents (reports, evidences and feedback) to CSU. 9. CSU submit an annual report and portfolio of activities to the college council.
Procedure	

Procedure steps	Responsibility
1. CSU prepares a community services activities plan annually based on the Saudi community needs through survey as well as staff and students' feedback.	**CSU**
2. CSU submits annual community services activities calendar to college council for approval.	**CSU**
3. All MBBS staff and students should be involved in planning for community services activities.	**CSU**
The CSU publishes the approved community services activities calendar on the college website.	**CSU**
5. The approved community services activities calendar circulates to the staff and students of MBBS Program to give them equal opportunity to select the service activity.	**CSU**
6. MBBS Staff and students will be assigned for each service activity.	**CSU**
7. The assigned group of staff and students for each service activity are responsible to submit	**SCU**

	all the documents (reports, evidences and feedback) to CSU.	
8.	Certificates of attendance will be prepared through the CSU within one week after the activity and will be sent to participants electronically after each activity.	**CSU**
9.	CSU submits annual report and portfolio of activities to the CC.	**CSU**

Fakeeh College for Medical Sciences	**Policy Number: FAC-MBBS-6**	
Policy Title: Employee Code of Conduct Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 22-1-2024	
Applicable to: MBBS Program	**To be Reviewed on: 22-1-2029**	

Statement of the Purpose	1. This Code of Conduct contains the policies that relate to the legal and ethical standards of conduct that Fakeeh College for Medical Sciences Board of trustees, Executive Management, and staff are expected to comply with while carrying out their fiduciary duties and responsibilities at the college. 2. This policy is intended to help concerned persons focus on areas of ethical risk, provide guidance to help them recognize and deal with ethical issues. It also

	provides mechanisms to report unethical conduct, and to help foster a culture of honesty and accountability.
Policy	1. The Code of Conduct complements, but does not replace, the standards of behavior and performance required by the college regulations. 2. The code of conduct clarifies the standards of behavior that are expected of staff in the performance of their duties and responsibilities. It gives guidance in areas where staff need to make personal and ethical decisions. 3. All MBBS program faculty and staff shall comply with the laws, rules, and regulations applicable to FCMS. 4. Conflict of Interest: 5. All MBBS program staff and faculty shall avoid conflicts of interest between themselves and FCMS. A "conflict of interest" can occur when the private interest of any of the MBBS program staff and faculty in any way or even appears to interfere, with the interests of FCMS. A conflict situation can arise when any of the MBBS program staff and faculty take actions or has interests that may make it difficult to perform their work objectively and effectively. Conflicts of interest also arise when any of the MBBS program staff and faculty, or a member of their immediate family, receives improper personal benefits because of their position at FCMS. 6. Each MBBS program staff and faculty shall fully disclose any situation that involves or may reasonably be expected to involve a conflict of interest. Moreover, all MBBS program staff and faculty shall report any conflict of interest to their Head of Department. 7. Gifts: 8. All MBBS program staff and faculty shall not accept gifts or personal benefits of any value from external parties if it could be perceived that this could compromise or influence any of the college staff and faculty decision. Additionally, no gift shall be accepted from a supplier, vendor, contractor or a student. 9. Entertainment: 10. Acceptance of normal business entertainment such as lunch, dinner, an event, and the like, generally is appropriate if it is of a reasonable nature and is during a meeting or another occasion. The purpose of which is to hold genuine business discussions or to foster better business relations. All MBBS program staff and faculty are to report any such entertainment to their Head of Department. 11. Outside Activities: 12. All MBBS program staff and faculty are prohibited from engaging in any freelance activity or employment that adversely affects the quality or quantity of work performed; or adversely affects FCMS reputation; or makes use of FCMS'- time, facilities, resources or supplies. 13. Interests in Other Businesses: 14. It is a potential conflict of interest for all MBBS program staff and faculty or their spouses or any other immediate family members (jointly referred to as "family

members") to directly or indirectly have a financial interest (e.g., as an investor, lender or Board Member) in a competitor, or in a customer or supplier with whom that MBBS program staff and faculty or their subordinates deal in the course of their job within FCMS. Accordingly, employees must promptly disclose any such interests to their supervisor.

15. In addition, an employee must disclose to their department director any employment or consulting relationship that a family member has with a competitor, or with a customer or supplier with whom the employee has dealings.
16. Corporate Opportunities:
17. MBBS program staff and faculty have a duty to advance college legitimate interests when the opportunity to do so arises. They are, therefore, prohibited from:
18. Taking for themselves personally opportunities that are discovered through the use of college property, information or position for personal gain.
19. Harassment:
20. MBBS program staff and faculty are committed to a working environment which is free from harassment, including discrimination, victimization and bullying, and in which the dignity of the individual is paramount. As such, all concerned persons are responsible for helping to ensure that individuals do not suffer any form of harassment. Any staff who suffer from harassment will have the total support of MBBS program management in putting a stop to it.
21. Nepotism Disclosure:
22. FCMS does not prohibit the employment of relatives, and it does not wish to become involved in consensual relationships between co-workers. However, precautions must be taken to ensure that individuals are not and do not appear to be improperly influenced by the existence of close personal relationships. In particular, MBBS program staff and faculty may not directly supervise or otherwise participate in decisions regarding the hiring, retention, promotion or compensation of other MBBS program staff and faculty with whom they have a close personal relationship.
23. Employee Relations:
24. It is the MBBS program policy that all staff and faculty, regardless of level, shall strive to meet the following objectives:
    - 24.1. Respect each employee, worker and representative of students, suppliers and contractors as an individual, showing courtesy and consideration and fostering personal dignity.
    - 24.2. Make a commitment to and demonstrate equal treatment of all employees, workers, students, suppliers, and contractors with regard to race, color, gender, religion, age, national origin, citizenship status or disability.
    - 24.3. Provide a workplace free of harassment based on race, color, gender, religion, age, national origin, citizenship status or disability.

24.4. Afford employees a reasonable opportunity, consistent with the needs of MBBS program, for training to become better skilled in their jobs.

24.5. Encourage promotion from within, consistent with the needs of MBBS program, whenever qualified employees are available.

24.6. Treat any suggestions by external consultants brought in to enhance our processes as opportunities to improve skills and not as criticism. Provide and maintain a safe, healthy and orderly workplace.

24.7. Assure uniformly fair compensation and benefit practices that will attract, reward, and retain employees.

25. Safety:

26. MBBS program is committed to provide a safe workplace for staff. In addition, there are laws and regulations that impose responsibility to safeguard against safety and health hazards.

27. For those reasons, MBBS program staff and faculty who are present at the college facilities are required to follow all safety instructions and procedures that MBBS program and FCMS adopts. If MBBS program staff and faculty have any questions about possible health and safety hazards at any of our facility, they shall bring those questions to the attention of their supervisor as soon as possible.

28. Confidential Information:

29. Except when disclosure is authorized, legally mandated, or required by law, all MBBS program staff and faculty shall maintain and protect the confidentiality of information entrusted to them about students, work colleagues, suppliers, stakeholders and the college business and financial affairs. “Confidential information” includes all non-public information that might be of use to competitors, or harmful to FCMS or its student, if disclosed.

30. Fair Dealing:

31. All MBBS program staff and faculty shall endeavor to deal fairly with the college students, suppliers, competitors and employees. None shall take advantage of anyone through manipulation, concealment, abuse of privileged information, misrepresentation of material facts, or any other unfair-dealing practice.

32. Corruption and Bribery:

33. Bribery occurs when anyone offers, solicits, gives, receives or accepts anything of value in exchange for favorable treatment by a Company, government authority or official. It also occurs when a company secures an unfair advantage over its competitors through secret and corrupt dealings with prospective customers. Bribery is illegal, and any of MBBS program staff and faculty who elicits, participates in or condones a bribe, kickback, or other unlawful payment or attempts to participate in any such activity, will be subject to strict disciplinary action, up to and including termination.

34. FCMS also reserves the right to refer such matters to public authorities for possible criminal prosecution.

35. Protection and Proper Use of Company Assets:

	36. All MBBS program staff and faculty shall protect the college assets and ensure their efficient use. Theft, carelessness and waste have a direct impact on FCMS's profitability. As such, FCMS assets are to be used only for the legitimate business purposes of FCMS and its subsidiaries and only by authorized employees or their designees. This includes both tangible and intangible assets. Some examples of tangible assets include Company vehicles and office equipment such as phones, copiers, computers, furniture, and supplies. 37. FCMS email system shall be restricted primarily to Company business. Highly confidential information shall be handled appropriately. Files containing sensitive business data shall be appropriately password protected. FCMS reserves the right at any time to monitor and inspect, without notice, all electronic communications data and information transmitted on the network and electronic files located on personal computers owned by FCMS or computers on the premises used in company business. 38. Third party software is provided as a productivity tool for employees to perform their job functions. 39. Advertising and Promotional Activities: 40. False, misleading or deceptive advertising and related activities in the promotion made by MBBS program staff and faculty may be liable as individuals for illegal software use. To the extent permitted under applicable laws, employees, contractors and temporary employees shall assign to MBBS program any invention, work of authorship, composition or other form of intellectual property created during the period of employment. 41. Fair and accurate advertising and sales practices are critically important in preserving FCMS goodwill and reputation with its students and the general public. Therefore, all advertising claims and other representations to students' and potential students must be truthful and have a reasonable basis. In addition, all advertising claims, whether made in catalogues, brochures, leaflets, posters, newspapers, magazines or other print as well as non-print media, must be substantiated before publication or dissemination. 42. Accurate Record Keeping and Reporting: 43. MBBS program staff and faculty shall accurately reflect the transactions of in its books, records, accounts and reports and shall maintain an adequate system of internal controls and disclosure controls to promote compliance with the laws, rules and regulations applicable to FCMS. All MBBS program staff and faculty will, to the best of their ability, use reasonable endeavors to ensure that FCMS records and documents, including financial reports, are true and correct. Falsification of any company record is prohibited. All reports, documents or communications authorized or legally mandated for disclosure to the public shall be full, fair, accurate, timely and understandable. 44. Influences on the Conduct of Audit:

45. MBBS program staff and faculty must not take any action to fraudulently influence, coerce, manipulate or mislead any auditor performing an audit or review of MBBS program financial statements.
46. Reporting of Illegal or Unethical Behavior:
47. MBBS program staff and faculty shall promote ethical behavior and shall encourage employees to talk to supervisors, directors or other appropriate personnel when in doubt about the best course of action in a particular situation. The MBBS program staff and faculty shall report illegal or unethical behavior, of which they become aware of. As such, all executive management, managers and employees shall report illegal or unethical behavior to their direct line supervisor. Violations will be investigated and action will be taken by the appropriate personnel or the Board as necessary. MBBS program management will not allow retaliation for reports made in good faith.
48. Corporate Governance and Accountability:
49. MBBS program management is committed to high standards of corporate governance.
50. Plagiarism: When a case of plagiarism is suspected, it must be reported to the disciplinary committee. This committee will investigate the case and apply the penalty according to regulations mentioned in the policy (Refer to plagiarism policy.

Procedure

Procedure steps	Responsibility
1. New employees are required to sign a copy of Code of Conduct upon joining the college, and a signed copy is placed in the employee's personnel file. (See attachment: 1)	**Employee and HR manager**
2. Code of conduct must be included as part of the staff orientation program and they need to sign the code of conduct form.	**Staff Development Unit (SDU)**
3. An electronic copy of the code shall be present on college website, accessible to all employees.	**Vice Dean for Development and Quality Management (VDDQM)**
4. It is the responsibility of MBBS program directors to monitor compliance with the Code of Conduct and to initiate disciplinary action against employees who do not abide by the tenets of the Code.	**Heads of Departments (HoD) and Program Director (PD)**
5. **Conflict Disclosure**	
5.1. Human Resource (HR) Manager must ensure that all staff members are familiar with college policies and	**HR Manager**

	procedures related to Conflict of Interest through orientation program.	
5.2.	All staff members should complete and promptly submit a disclosure form to the HR Manager upon employment. Upon employment and thereafter at any point if staff has discovered or suspects that an actual, potential, or perceived conflict of interest exists or could arise from a situation or activity must report this to HOD.	**Staff, HOD and HR Manager**
5.3.	Upon receipt of a complete disclosure, the HOD will forward the case to department council/college council for a decision.	**HOD, PD, College Dean**
5.4.	Staff Member can expect disposition within a reasonable time frame (normally 15 calendar days).	**College Dean**
5.5.	In the case of the college Dean, the Chair of the Board of Trustees shall act in the place of the College Council.	**The Chair of Board of Trustees**
5.6.	If any employee breaches the rules and regulations issued by the college shall be subject to disciplinary action.	**College Dean**
	Disciplinary actions which may be imposed on employee are:	**College Dean**
5.6.1.	Draw attention (Reprimand)	
5.6.2.	First Warning	
5.6.3.	Second Warning	
5.6.4.	Deduction from salary	
5.6.5.	Suspension without salary	
5.6.6.	Demotion	
5.6.7.	Dismissal	
5.7.	All MBBS program faculty and staff must refrain from the following activities according to regulation:	
5.7.1.	Undue personal gain from college funds or resources.	**MBBS program faculty and staff**
5.7.2.	Excessive or unauthorized use of college time or resources for professional, charitable or community activities.	

		5.7.3. Exploitation of students for private gain.	
		5.7.4. Compromise college priorities due to personal financial considerations.	
		5.7.5. Unfair access by an outside party to college programs, services, information or technology.	
		5.7.6. Selection of an entity as a college vendor by an individual who has a personal or financial interest in that entity; this includes engaging a relative as an independent contractor, subcontractor or consultant.	
		5.7.7. Situations in which a MBBS program faculty and staff directly dealing with students who are an immediate family member of the faculty or staff.	
		5.7.8. The MBBS program faculty and staff members are not allowed to enter into agreements, contracts, or purchases that give rise to a Conflict of Interest unless the conflict can be eliminated or appropriately managed through administrative oversight to protect the interests of the individual and the College.	
		5.7.9. FCMS resources are to be used only in the interest of the College. Faculty and Staff may not use college resources, including facilities, personnel, equipment or confidential information, as part of their outside consulting activities or for any other non- college purposes.	
		5.7.10. MBBS program faculty and staff are not allowed to render any services to any person or company, in any capacity, during their service in the college, with or without pay.	
		5.7.11. Favors of any value should be recognized for their potential influence on the objectivity of judgment with	

	respect to the provider and the recipient of the favor. Faculty and Staff shall not solicit a gift or accept a significant gift when such solicitation or acceptance may influence, or have the appearance of influencing, the performance of the duties.	
5.7.12.	The MBBS program faculty and staff shall refrain from using college name and logo and any of the college means of communication in activities or businesses not related to the college.	
5.7.13.	MBBS program faculty and staff should complete and promptly submit a conflict disclosure form to the HOD after the member has discovered or suspects that an actual, potential, or perceived conflict of interest exists or could arise from a situation or activity.	
5.7.14.	MBBS program faculty and staff member makes the commitment when hired by FCMS to promote confidentiality and abide to the college Policies and Procedures.	
5.7.15.	All MBBS program faculty and staff have to report to the direct supervisor any acceptance of normal business entertainment such as lunch, dinner and the like to foster better business relation.	
5.7.16.	All MBBS program faculty and staff are responsible to ensure that individuals do not suffer from any form of harassment. Any staff suffer from any kind of harassment can raise this issue to the staff disciplinary committee.	
5.7.17.	All MBBS program faculty and staff are obliged to follow the FCMS safety regulations any violations will lead to disciplinary action.	

Learning Resources, Facilities and Equipment

Fakeeh College for Medical Sciences	**Policy Number: LRFE-MBBS-01**	
Policy Title: Website Maintenance and Upgrade Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 20-6-2019	
	Last Version Approved on: 15-01-2024	
Applicable to: MBBS Program	**To be Reviewed on: 15-01-2029**	

Statement of the Purpose	This policy aims to outline the actions that must be followed to comply with FCMS Website development and upgrade Procedure.
Policy	1. The FCMS and MBBS Program stakeholders perform regular audits to the website content to ensure that is accurate and up-to-date.

Procedure	

Procedure steps	Responsibility
1. **<u>Website maintenance</u>**: The activities from which the FCMS Website Maintenance is composed are: 1.1. Website Publishing: To keep content up-to-date. 1.2. Website Quality Assurance: To spot errors on a site. 1.3. Website Feedback Monitoring: To manage communication with website Visitors. 1.4. Website Performance Monitoring: To measure network and internet speed. 1.5. Change Control: To manage technical and other changes in a coordinated way.	**IT Unit**
2. A website maintenance request is prepared and delivered to the website developer for execution and implementation, every time. 2.1. An error has been discovered in the content language. 2.2. Incorrect information is detected in the content. 2.3. An amendment to the MBBS Program, plans, and curriculum has been applied. 2.4. A new event that needs to be published. 2.5. A new rule for student admission will be in effect. 2.6. A new academic calendar to be published.	**IT Unit**
3. **<u>Website upgrade:</u>** When the MBBS top management or the Information Technology (IT) team identify the need to develop a new website or to redesign the existing website, then an RFP will be developed and submitted to the specialized website development companies for proposals.	**IT Unit**

	4. The IT Unit with the HOD will develop a web project outline that: 4.1. Identifies the designees from each department and unit who will be responsible for the content of the Website. 4.2. Explains how the Website will support the MBBS program or unit's business goal(s) and the college's institutional goals. 4.3. Identifies the audience that the Website is intended to serve. 4.4. Defines the scope of work for the website.	**IT Unit and HOD**
	5. Upon receipt of the proposal, the Web development company will meet with the Website Owners and any other relevant stakeholders to confirm the scope and needs of the Website.	**Web development company**
	6. Website Owners must ensure that all content on the Website complies with any relevant Copyright restrictions.	**IT Unit**

Fakeeh College for Medical Sciences	**Policy Number: LRFE-MBBS-02**	
Policy Title: Waste Management in FCMS Laboratories Policy	☐ **New**	☑ **Revised**
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: MBBS Program	**To be Reviewed on: 15-01-2029**	

Statement of the Purpose	To provide guidelines and goals for implementing proper waste management in Fakeeh College for Medical Sciences (FCMS) laboratories entities whilst ensuring safety of all workers, students, environment, and the general public.

Policy	1. FCMS and MBBS Program shall adopt the Unified Guideline for Infectious Waste Management by GCC while monitoring the waste generation, segregation and transportation to the BHR. 2. FCMS and MBBS Program shall adhere to DSFH Infection Control regulation in handling waste with the collaboration of SSD and Organization Units Leaders (OUL). 3. The Infection Control Department shall assist FCMS and MBBS Program in providing staff education (new and existing employees) about waste management, proper sorting of waste according to types, safe handling with use of appropriate personal protective equipment's and the potential health and safety risks waste poses, safe interim storage through appropriate use of defined, color-coded bags and/or container-identification system and final disposal via contracting parties. This information shall be included in the New Employee Orientation Program. 4. SSD shall be responsible for finalizing the waste disposal transportation as well as dealing with a specific contractor for proper disposition. 5. A Chemical Waste Declaration Form shall be completed by FCMS Laboratory Manager or FCMS Safety and Security Manager and submitted to SSD declaring the chemical volume and types for proper disposal. 6. FCMS Entities has contracted company Saudi Gulf Environmental Protection Company (SEPCO) to handle/dispose all its biohazards waste as per the GCC requirement. 7. Fakeeh Care Entities has contracted company to compress and collect all the non-hazardous waste and dispose it as per the GCC requirement.
Procedure	

Procedure Steps	Responsibility
1. Standard Precautions shall be applied by all FCMS when handling waste.	**Laboratory Supervisor/ Teaching Assistant/ Clinical Instructors/ Housekeeping**
2. Housekeeper shall not use their barehand when handling or packing wastes.	**Housekeeping**
3. Housekeeping shall provide receptacles that are conveniently located and lined with appropriate color-coded plastic bags for waste collection and sorting in areas where both non-hazardous and hazardous waste are generated.	**Housekeeping**
4. Collection **of Hazardous waste:** FCMS entities shall sort the hazardous waste as followed:	**Laboratory Supervisor/ Teaching Assistant/ Clinical Instructors/ Housekeeping**
4.1. **Infectious waste**	
4.1.1. Shall be collected in yellow-colored plastic bags bearing the phrase "Infectious Waste" along with biohazard symbol. 4.1.2. Housekeeping shall remove bags of infectious waste wearing gloves from all FCMS Multipurpose Laboratories when ¾ filled and whenever necessary. 4.1.3. Assigned housekeeping shall remove all bags of infectious waste from local unit/department and transfer them to BHR whenever necessary. 4.1.4. Before transfer, the housekeeping assign shall recheck bags for completeness of data sticker proper color coding, over filling or leaking. 4.1.5. If any of the above is witnessed by the housekeeper, he/she shall report to their supervisor to asset in solving the problem and follow the below. 4.1.5.1. Name of the waster generator. 4.1.5.2. If wrong color coding was applied, He/she shall put the wrong bag color inside the correct color without re-opening or emptying the bag and shall initiate an Occurrence Variance Report (OVR).	

	4.1.5.3. If the waste bag is leaking, housekeeper must wear proper PPE (gloves gown, mask) and place the leaking bag in double bags matching its color and remove it away from the leaking area and contain the leak. 4.1.5.4. If the waste bag is filled more than 3/4 place, he/she shall double bag it and initiate OVR. 4.1.5.5. If sharp disposal witnessed in the waste bag, he/she shall place the waste bag in sharp container without opening it and initiate OVR. 4.1.5.6. Housekeeper shall use the designated and covered Hazardous waste bin and dedicated trolley during transport. 4.1.5.7. Wash bins daily, dry and then reline with big yellow bags bearing phrase "Infectious Waste" along with biohazard logo. 4.1.5.8. The housekeeping staff shall perform hand hygiene following all types of waste disposal. 4.1.5.9. A special contractor shall collect and transport all infectious and hazardous waste from the BHR to their treatment and disposal facility on a daily basis.	
	4.2. **Laboratory** waste such as Cadaver Parts	**Anatomy Personnel/ Laboratory Supervisor/ Housekeeping**
	4.2.1. Specimen preserved in formalin shall be segregated from other waste and formalin should be disposed as a chemical waste and the specimen (cadaver parts) shall be placed in yellow bag with "Caution" sign along with data sticker. 4.2.2. The disposition of cadaver parts shall be handled accruing to the FCMS Disposition of Cadaver Parts Policy.	
	4.3. **Solid Chemical Waste**	**Laboratory Supervisor/ Housekeeping**
	4.3.1. Shall be collected in yellow sturdy, puncture proof container bearing the phrase plastic bag with "Caution" sign.	

	4.3.2. The category solid, liquid, and gaseous chemicals shall be identified in attached data sticker. 4.3.3. Housekeeping shall provide the appropriate bins lined with yellow plastic with “Caution” logo and shall be filled no more than 3/4 capacity.	
	4.4. **Liquid Chemical Waste**	**Laboratory Supervisor/ Laboratory Manager/ Housekeeping**
	4.4.1. Concentrated chemicals, even in small quantities, should not be discharged into sewer. 4.4.2. Other liquid chemical waste (such as corrosive, reactive, flammable, or toxic) shall be collected in thick, sealed, leak proof container/bottle then placed inside yellow bags with “Caution” logo. 4.4.3. Relevant Laboratory Supervisor shall prepare chemical waste manifest stating the volume and content of generated chemical waste. 4.4.4. Housekeeping shall attach data sticker and shall write the type “Chemical Waste” on each individual container; then shall place them inside yellow bags with “Caution” logo to be transported to BHR. 4.4.5. Chemical waste manifest shall be handed over to Laboratory Manager then to the BHR staff during chemical waste transport. 4.4.6. Housekeeping assigned shall transfer chemical waste to BHR.	
	4.5. **Chemical Spillage Management**	**Laboratory Supervisor/ Laboratory Manager/ FCMS Safety & Security Unit Manager Housekeeping/ DSFH Spill Team**
	4.5.1. If Chemical spillage incident occurred, the Employee discovering the spill shall call the spill team by dialing 72222 in order to activate Code Orange (Hazardous Material Spill/Release). 4.5.2. The incident reporter shall give his/her name, exact location of spill and a brief description of the incident (type of spill) and stay on the telephone line until the	

		clean-up team Responder verifies the information. 4.5.3. If fumes or other immediate hazards seem present, persons should be evacuated from the affected area and the location should be contained as possible. 4.5.4. FCMS Safety & Security Unit Manager shall limit that accessibility to the affected area. 4.5.5. The Spill clean-up must be carried out by a well-trained spill team. 4.5.6. Only staff that has received education and training about clean-up procedures for hazardous material spill will perform the procedure. 4.5.7. In case of fire, set off fire alarm and extinguish flames. 4.5.8. PPE as well as Chemical Spill Kit must be provided in all Multipurpose Laboratories to be utilized in case of any spillage incident. 4.5.9. Laboratory Manager shall Fill in an (OVR) to report spillage or leak.	
		4.6. **Sharps Waste**	**Laboratory Supervisor/ Teaching Assistant/ Clinical Instructors/ Housekeeping**
		4.6.1. Shall be collected in sturdy, puncture proof container bearing the phrase “Danger, Sharps Infectious Waste” along with biohazard logo. 4.6.2. Needles, scalpels and sharps require special handling because they pose the greatest risk of injury. 4.6.3. Laboratory Supervisor is responsible of sharps container assembly, placement and replacement. 4.6.4. The relevant staff must place the sharps containers over stable surfaces or guarded inside locked wall mounted holders, and at below eye level for easy and safe sharps disposal. 4.6.5. The relevant staff must close the lid of sharps containers (all types and sizes) tightly whenever three quarters (¾) filled.	

	4.6.6. Housekeeping staff assigned shall place the containers in yellow plastic bag with phrase "Infectious Waste" along with biohazard logo to contain be responsible in transferring contained, sealed sharps waste to BHR.	
	4.7. **Handling Non-Hazardous Waste:** 4.7.1. Non- Hazardous waste generated by FCMS Entities shall be disposed in designated bins lined with black plastic bag along with data sticker for identification. 4.7.2. Paper wastes such as catalogues, posters, etc should be recycled through the Property Control. 4.7.3. The housekeeping assigned shall remove waste on regular basis; at least once per shift and whenever necessary (¾ filled) and attached a data sticker. 4.7.4. Data sticker shall have the following information: 4.7.4.1. Name of the waste generator unit. 4.7.4.2. Type of waste generated. 4.7.4.3. Name and signature of housekeeper. 4.7.4.4. Date and time of collection. 4.7.4.5. At the end of each shift, the housekeeping assigned shall transport all collected Non-Hazardous waste to contractor-provided bins. 4.7.5. Housekeeping must wear gloves when handling, sorting and packing waste. 4.7.6. Housekeeping assigned shall use dedicated trolley during transport. 4.7.7. Housekeeping assigned shall follow the designated routes of waste transport inside Fakeeh Care premises. 4.7.8. Housekeeping staff shall perform hand hygiene after waste disposal. 4.7.9. Daily and whenever necessary, the Non-Hazardous Waste contractor collects,	**Housekeeping/ Property & Inventory Control Officer Outsourcing Contractor**

		transports and finally disposes the Non-hazardous waste to sanitary landfills.	
	4.8.	**Waste Management in the Biohazard Room (BHR):** Refer to DSFH policy No. IC-APP-280.	**BHR Staff/ Housekeeping**
	4.9.	**Healthcare risk waste collection by contracting party:** Refer to DSFH policy No. IC-APP-280.	**BHR Staff/ Contractor Company**

Fakeeh College for Medical Sciences	Policy Number: LRFE-MBBS-03	
Policy Title: Library Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose

1. This policy statement is designed to serve as guide to the library personnel and library users alike.
2. To provide a dynamic educational role, there should be stipulation to guide our objectives and all procedures to realize the main objectives of the library, specifically this policy will;
3. Ensure that the objectives of the library are attained to help in the college mission and vision.
4. Ensure that informational resources are acquired to help the academic community in the learning and teaching process and research.
5. Provide conducive learning environment by providing quality information resources and facilities.

Policy

1. The library commits to inculcate a passion for excellence through research, study and information science. In keeping with the mission, information resources are readily accessible to the library users.
2. Two library branches will serve the male and female respectively and will be operating in the following timings:

Library Section	Sundays to Thursday
Main/Female (6th Floor)	8:00 a.m – 4:00 p.m.
Male/Affiliate (3rd Floor)	8:00 a.m – 4:00 p.m.

An orientation shall be conducted to all new employees and staff as well new students and transferees beginning of each academic year. Current awareness program should also be held to further inform the academic community on the policy and guidelines of the library as well as on how to maximize use of available resources.

Procedure

Procedure Steps	Responsibility
1. Library Rules and Regulation	**Librarian**

1.1. All library users will be asked to sign in the "Daily Library Monitoring Form" upon entering the library.
1.2. Identification card shall be presented upon loaning any materials or availing any library services.
1.3. Eating, drinking, smoking and sleeping in the library is not allowed.
1.4. Talking loudly and making loud discussions. Silence must be observed at all times
1.5. Doing unnecessary activities that may disturb other users is prohibited.
1.6. Littering and loitering are prohibited.
1.7. Playing online game in cell phone, computer and other gadgets is not allowed.
1.8. Cellular phones must be in silent mode.
1.9. Proper dress code must be observed.
1.10. Valuable things including laptops can be brought inside the library, however the librarian is not responsible in case of loses.

2. **Photocopy & Printing Services:**

Photocopying and printing services are deployed to help the library users. However strict compliance to copyright law must be observed all the time. To observe the copyright law the following guidelines must be observed.

2.1. **Print Resources:** Maximum of a chapter or at most 10 pages, whichever is higher can be copied at a time.

2.2. **Digital Resources:** As per publisher allowance on downloading. Copying machine is available at the following price:

Photocopy/Black &White	
No. of Pages	**Amount in SR**
1-8	1

Printing			
Black & White		**Colored**	
No. of Pages	**Amount in SR**	**No. of Pages**	**Amount in SR**
1-4	1	1	1

Librarian

6.

	3. **Lost and Damaged Book:** All lost and damaged library materials will be charged with its equivalent market value plus SR100 as processing fee.	**Librarian**
	4. **Borrowing of Library Materials** **4.1.Faculty, Staff & Affiliates:** 4.1.1. Every book contains a "borrower's card" which contains all the relevant information of the book and will be signed by the borrower upon borrowing the book. 4.1.2. Each user is allowed to borrow two (2) books for a period of five (5) days. 4.1.3. The user completes the borrower's form to borrow the books. 4.1.4. It is the responsibility of the borrower to remember the due dates of the library items. 4.1.5. The borrowers are responsible for returning the book on the last due date and for any book not returned on time, the borrowers will be accessed an overdue fine of SR10 per day per item. If borrower did not return the book for 3rd week, he/she will be deprived to borrow any books for a period of one month on the current semester. 4.1.6. Each book is checked for damage according to its condition. This is to check the books being returned if there are any writings or damages happened. Charges will be applied on the extend of the damages.	**Faculty/Staff members/ Students**
	5. **Selection and Acquisition of Library Resources** **5.1.Print Resources:** 5.1.1. Before the beginning of each academic year, the head of department (HOD) communicates with the faculty to assess the needs for updated books, new books, references or any other required teaching materials. 5.1.2. Each faculty prepares a list of required references and submits it to the HOD. The HOD will compile the entire list from the entire faculty. 5.1.3. The HOD prepares a comprehensive list and submit it to Vice Dean Academic Affairs	**HOD** **Faculty Members** **HOD**

	(VDAA), to be endorsed by the library unit for the Dean's approval.	**Librarian**
	5.1.4. After Dean's approval, the list will be sent to the librarian for procuring.	
	5.1.5. Upon arrival of new books, the librarian will send the list of new books and materials available in the library to the HOD.	**Librarian**
	5.1.6. The HOD will notify the faculty on the availability of new books in the library.	**HOD**
	5.1.7. The process should start at the end of each academic year and to complete it minimum two weeks before the start of the new academic year.	
	5.2. Digital Resources (SDL):	**HOD**
	5.2.1. Before the beginning of each academic year, the HOD communicates with the faculty to assess the needs for specific database needed for the program.	**Faculty Member**
	5.2.2. Each faculty prepares a list of required references and submits it to the HOD.	**HOD**
	5.2.3. The HOD prepares a comprehensive list and submit it to VDAA and for the Dean's approval.	**Librarian**
	5.2.4. After Dean's approval, the list will be sent to the librarian for procuring.	
	5.2.5. Compiled list of suggested databases will be forwarded to the IT Unit to communicate with the respective publishers.	
	5.2.6. Upon arrival of new books, the librarian will send the list of new books and materials available in the library to the HOD.	**HOD**
	5.2.7. The HOD will notify the faculty on the availability of new databases in the library.	
	5.2.8. The process should start at the end of each academic year and to complete it minimum two weeks before the start of the new academic year.	
	6. **Cataloguing & Classification**	**Librarian**
	6.1. Books:	
	6.1.1. All books shall be stamped with the college ownership logo.	
	6.1.2. An equal number of copies shall be designated between male and the female libraries. In case of a single copy, only the female shall be	

allocated but can be transferred upon requested or upon inter-library loan procedures.

6.1.3. Using the KOHA cataloguing modules, ISBN of the book shall be scan to locate its MARC record via Z39.5 modules.

6.1.4. Library of congress subject and classification shall be adopted for all library materials.

6.1.5. Customized barcode ID will be automatically generated.

6.1.6. A call number shall be generated based on the library of congress classification system with the following details; main class, subclass, author, copyright and copy number.

6.1.7. Color coding shall also be adopted to easily identify library resource designation with:

Color		Department
	Blue	Department of Clinical Sciences
	Yellow	General Reference
	Black	General Circulation
	Black	Pathological Sciences
	Black	Physiological Sciences
	Black	Basic Sciences and General Requirements

6.2 Non-Books:

6.2.1. All other library resources aside from books and those that are found in the SDL shall be considered non-book resources notably the DVD use for instructional learning.

6.2.2. Similar to cataloguing and classifying books in KOHA, only the format will be selected to DVD instead books format.

6.2.3. Using the KOHA cataloguing modules, ISBN of the book shall be scan to locate its MARC record via Z39.5 modules.

6.2.4. Library of congress subject and classification shall be adopted for all library materials.

6.2.5. A customized barcode ID will be automatically generated.

Librarian

	6.2.6. A call number shall be generated based on the library of congress classification system with the following details; main class, subclass, author, copyright and copy number	
	7. Clearance, Fine & Penalty **7.1. Faculty and Staff and Other Affiliates:** 7.1.1. A clearance shall be obtained by all faculty and staff every semester. 7.1.2. There shall be no loaning for all library resources at least one (1) month before the final examination day. Only library reading is allowed. 7.1.3. Damaged/Lost books and other library resources shall be charged with the prevailing market price in addition of 100 SR as processing fee. 7.1.4. Late fines shall be charged of 10 SR per day per book before clearance shall be signed. 7.1.5. Library shall forward to Human Resources Unit the list of faculty and staff with accountability in the library at end of each semester. 7.1.6. Any faculty/staff member is not allowed to leave the college, either for annual leave or upon resignation without being cleared from the record of the Library shall forward to Human Resources Department the list of faculty and staff with accountability in the library at end of each semester. **7.2. Students & Interns:** 7.2.1. Ensure that no student accountability in the library at the end of the semester by communicating directly to them to return all loaned items. 7.2.2. There shall be no loaning for all library resources at least one (1) month before the final examination day. Only library reading is allowed. 7.2.3. Postgraduate Students shall submit a soft copy of the final approved version of their theses and at least 2 copies of hardbound to the library attaching the “Theses Submission Form” before clearance shall be granted.	**Librarian** **Faculty and Staff** **Librarian** **Students and Interns**

	7.2.4. Damaged/Lost books and other library resources shall be charged with the prevailing market price in addition of 100 SR as processing fee. 7.2.5. Late fines shall be charged of 10 SR per day per book. 7.2.6. Library shall forward to IT unit the list of students with accountability at the end of the semester to lock/secured the students account in PeopleSoft.	
	8. Using the Discussion Rooms: 8.1. There shall be two discussion rooms allocated for both male and female libraries. 8.2. Reservation is at first come first serve basis. 8.3. Upon utilization, requestor shall claim the key in the library reception area. 8.4. Key of the discussion room shall be return to the library reception area upon after using the rooms. 8.5. Requestor shall be liable for any damages during the use of the rooms. 8.6. Strictly no food is allowed inside and shall be monitored by the library staff all the times.	**Librarian** **Faculty and Staff**
	9. Reserve Books: 9.1. There shall be reserve section to ensure that at least one copy of all library holding is always available in the library at all times. 9.2. Librarians will always have the discourse to allow or not to allow certain library item.	**Librarian**
	10. Saudi Digital Registration 10.1. Each bona fide member of FCMS and its affiliate (Fakeeh care Group) is entitled for Saudi Digital Library access. 10.2. A user agreement form shall be sign before the access shall be granted. 10.3. The user agreement form shall be returned back to the library for the account creation and should notified all applications via emails, telephone or any means convenient to both parties.	**Librarian**
	11. The Top Library User Awards:	**Librarian** **Library Manager**

	To encourage library readership, there shall be an awarding of the top library users award every semester that will receive a certificate and a token using the criterion of "most number of item loaned each semester". 11.1. Faculty & Staff: There shall be one male and female faculty top library user for each semester. 11.2. Top User for Students: 11.3. Top Library User for each semester from each program.	**VDAA**
	12. Library Income 12.1. The library shall exert effort to account all collected income from print/photocopying and fines and penalties. 12.2. Students/faculty availing the print/photocopying as well paying their fines and penalties shall be asked to sign in the "Income Form". 12.3. The Library manager and or its designated staff shall remit the money to the finance officer of the college in a monthly basis. 12.4. Receipt as a proof of remittance shall be reported to the finance unit director via email in a monthly basis.	
	13. Annual Inventory 13.1. At the end of every academic year, the library manager shall submit annual library inventory annexes to the annual report containing the following; 13.2. Total List of Collection. 13.3. List of Newly Acquired Collection during the Academic Year by Department. 13.4. List of Accountability/unreturned collection both by Faculty and Students. 13.5. List of Losses/replacement made	

Fakeeh College for Medical Sciences	Policy Number: LRFE-MBBS-04	
Policy Title: Learning Resources Policy	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	1. To provide the principles for selecting and providing access to learning resources to promote and support learning process and to meet the broad informational needs of MBBS Program. 2. To ensure a healthy learning environment that will encourage academic study and research for MBBS students and faculty staff according to the standard of Ministry of Education (MOE).
Policy	1. The purpose is to provide guidance to MBBS Program learning resources acquisition and retention of relevant and quality materials. This policy supports the mission and curriculum of MBBS Program, to encourage faculty staff, and students to use the facilities and learning resources.

Procedure

Procedure Steps	Responsibility
1. Learning Resources Material	
1.1. Learning materials and resources selected will be consistent with the MOE rules and regulations as standard for benchmarking.	**HOD**
1.2. Selection of learning resources based on the MBBS Program curriculum, and students' interests and abilities.	**HOD**
1.3. The acquisition and servicing of learning materials necessary for the effective conduct of courses and research are provided through MBBS program director and concerning Head of the Department by annual budgetary processes.	**HOD**

	1.4. Faculty members are expected to discuss in advance with the Head of the Department on anticipated needs for the next year to assist and update course specifications.	**Faculty Members and HOD**
	1.5. Head of the Department is responsible for preparing annual plan for the recommended needs of learning resources as requested from teaching staff of the department.	**HOD**
	1.6. Learning resources are fair, equitable, and supportive for male and female section. It may be used with an individual student, small, or large groups of students.	**HOD, Director of Administration and Finance (DAF)**
	1.7. MBBS Program staff is expected to assume proper responsibility for the protection, maintenance, and use of equipment and materials assigned to their area.	**MBBS Program staff**
	1.8. MBBS Program staff will be trained to ensure that they are proactive role when they used learning resources.	**MBBS Program staff**
	1.9. Selection of learning resources is an ongoing process which should include the removal of materials no longer appropriate and the replacement of lost or worn materials still of educational value.	**DAF**
	2. **<u>Information Technology (IT) Services:</u>**	**IT Unit**
	2.1. Information Technology (IT) will play a major role in learning resources provision, such as media services to provide faculty staff and students with a variety of technology resources and services.	
	2.2. IT Services provides support and management of Smart Board and English language lab, in addition to classrooms and specialty lab. are equipped (at minimum) with a projector and Lap-top.	**IT Unit**
	2.3. Learning materials and resources selected will be consistent with the MOE rules and regulations as standard for benchmarking.	**HOD**
	2.4. Selection of learning resources based on the MBBS Program curriculum, and students' interests and abilities.	**HOD**
	2.5. The acquisition and servicing of learning materials necessary for the effective	

	conduct of courses and research are provided through MBBS Program department by annual budgetary processes.	**Faculty members and HOD**
	2.6. Faculty members are expected to discuss in advance with the HOD on anticipated needs for the next year to assist and update course specifications.	
	2.7. HOD is responsible for preparing annual plan for the recommended needs of learning resources as requested from teaching staff of the department.	**Faculty members and HOD**
	2.8. Learning resources are fair, equitable, and supportive for male and female section. It may be used with an individual student, small, or large groups of students.	**HOD** **DAF**
	2.9. MBBS Program staff is expected to assume proper responsibility for the protection, maintenance, and use of equipment and materials assigned to their area.	**MBBS Program staff**
	2.10. MBBS Program staff will be trained to use learning resources.	**IT Unit / MBBS Program Staff**

Fakeeh College for Medical Sciences	Policy Number: LRFE-MBBS-05	
Policy Title: Clinical Skills Laboratory Safety	☐ New	☑ Revised
	Version-1 was Prepared on: 20-6-2019	
	Version-2 is Approved on: 15-01-2024	
Applicable to: MBBS Program	To be Reviewed on: 15-01-2029	

Statement of the Purpose	The purpose of this policy is to direct staff, faculty members and students of BSN Program on the laboratory safety guidelines and provide a safe environment to prevent workplace injuries and accidents while minimizing any risk the laboratories may pose.
Policy	1. Fakeeh College for medical sciences (FCMS) is committed to provide a safe laboratory environment for all stakeholder such as laboratory supervisor, Clinical Instructors, faculty and students. The goal of Program laboratory safety policy is to guide all staff on the safety regulations inside the laboratory to minimize the risk of injury or illness and maintain a safe workplace for everyone. 2. The Clinical Skills Laboratory is a learning environment that is often intended to simulate a real clinical setting. As a result, eating and drinking are not permitted.
Procedure	

Procedure Steps	Responsibility
1. Prior to performing any clinical/practical practices 1.1. Conduct orientation on safe utilization of mannequin and equipment to all faculty member using the laboratory. 1.2. Ensure safe storage of all laboratory supplies in its right place. 1.3. Chemical storage must comply with national and international regulations for chemical safety and hygiene.	**Clinical Instructor/ Laboratory Instructor**

	1.4. Orient the staff and students utilizing the lab on the safe disposal of all laboratory materials and proper segregation of sharp objects and pathological waste. 1.5. Demonstrate the Clinical skills to be practiced inside the lab safely.	
	1.6. Report Latex allergy to supervisor	**Student**
	2. Laboratory Design and Access	
	2.1. FCMS laboratories designed in accordance with Ministry of Education recommendations and guidelines.	**Director for Administration and Finance**
	2.2. FCMS Laboratories are facilitated with multiple safety equipment and materials according to the regulations of Saudi General Directorate of Civil Defense.	**Laboratory Manager/ FCMS safety and Security Unit Manager**
	2.3. FCMS laboratories are provided with spill kits in compliance to DSFH Infection Control Regulations 2.4. Access to FCMS laboratories is restricted, unauthorized personnel are not allowed to enter/access the labs. 2.5. Injury to unauthorized personnel in the lab will not be considered the responsibility of FCMS. 2.6. FCMS lab facilities shall be utilized only for experimental, clinical, and practical sessions only 2.7. Workspace shall be kept clear form any obstruction.	**Clinical Instructor/ Laboratory Instructors/ Students**
	2.8. Report any misconduct occurring during any practical sessions immediately to lab supervisor.	**Instructor/Students**
	2.9. Laboratory doors shall be kept always closed to prevent the air imbalance between the lab and corridors.	**Clinical Instructor/ Laboratory Instructors/ Students**

	2.10. Clinical Skill Laboratories shall not be used as a clinic for sick students, staff, or faculty members.	
	3. Infection Control	
	3.1. All member utilizing the lab shall practice proper hand hygiene prior to experiment and prior to leaving the premises. 3.2. Universal precautions shall be continuously followed. 3.3. Any needlestick injuries or exposure to infectious pathogen shall be contained in compliance with regulation of MOH & DSFH IC, then file an incident report and alert the authorized personnel. 3.4. Personal Protective Equipment (PPE) shall be implemented by students and faculty members during any contact with body fluids. 3.5. Gloves are mandatory when practicing and demonstrating any skills. 3.6. Gloves are provided for personnel using harsh disinfectants to clean the lab. 3.7. FCMS will constantly provide the PPE and distribute it amongst all laboratories to maintain the safety of all stakeholders.	**Clinical Instructor/ Laboratory Instructors/ Students/QAU**
	4. Clinical Skills Demonstration/Application Safety	
	4.1. Student should be well-prepared prior to the practical/ clinical session and should be aware of the procedure and skills expected in the session. 4.2. Student shall practice and re-demonstrate only the skills demonstrated to them by instructors.	**Clinical Instructor/ Laboratory Instructors/ Students**

	4.3. Expired medications must be kept in special cabinet and labeled for practice only. 4.4. Students shall be supervised and monitored when applying any clinical skills or manipulating any equipment. 4.5. Bottles, chemicals, containers, and fluids used or mixed in the lab shall be properly labeled as follows: Name of the Component, Preparation Date, and Initial of the person in charge. 4.6. Students will demonstrate venipuncture with a peer/classmate using sterile technique. Students will not be allowed to practice venipuncture on each other without supervision of an instructor. 4.7. Needles must be discarded in the sharp's container **ONLY.**	
	5. Anatomy Suite Safety	
	5.1. Staff and students should apply precaution and safety measures when contacting the chemical agents (Formaldehyde) used as preservatives	**Laboratory Instructor/ Student**
	5.2. Photography and videos of human cadavers are NOT permitted under any circumstances. It will be considered a serious disciplinary offence for a student to take pictures or possess pictures of the College's human cadavers. 5.3. Eating, drinking, or gum chewing is not permitted anywhere in the interior of the of the gross anatomy laboratory. 5.4. Pregnant or lactating students are advised to consult their physicians before performing any procedure in the anatomy lab.	**Students**
	5.5. Students are never allowed to open the cadaver body storage	

	5.6. Appropriate attire is required when performing any laboratory exercises, particularly dissecting.	**Anatomy Personnel/ Students**
	5.7. PPE including closed-toe shoes, gloves, lab coat, and protective eyewear (i.e. goggles and eyeglasses) must be worn. 5.8. Extreme care should be applied when using sharp instruments. 5.9. Keep all dissection instruments on the dissection trays. 5.10. It is recommended that you do not change scalpel blades, until given proper directions by your instructor. 5.11. After completion of dissection, leftover tissues on tray should be disposed appropriately in the yellow biohazard bags found at your cadaver tank. Refer to Policy No. IRN-30. 5.12. Dispose of scalpel blades ONLY in the Red sharps/biohazard containers.	**Anatomy Lab Personnel/ Students**
	6. Electrical Safety 6.1. Maintain a workspace clear of extraneous material such as books, papers, and bags and clutches. 6.2. Turn off the power of equipment after any experiment. 6.3. Do not use or store flammable solvents near electrical equipment. 6.4. Keep access to electrical panels and disconnect switches. 6.5. Equipment and electrical outlet shall be kept safe and away from any water/wet sources. 6.6. Laboratory electrical outlets shall be inspected frequently. Any frayed electrical cords, cracked plugs, missing outlet covers, as any problems encountered while using electrical equipment shall be reported immediately to Maintenance unit for immediate action and resolution.	**Laboratory supervisor/ Maintenance Unit**

	6.7. Electrical extension is prohibited inside the premises. However, Cable trunk can be installed by an electrician to cover and protect any long electrical cords.	**Maintenance Unit**
	6.8. Only three-prong plugs that contain a ground wire should be used to power equipment in the skills labs. 6.9. Electric hospital beds in the skills lab will be inspected as needed for repair.	**BME**
	7. Ergonomics solutions 7.1. Instructions will be given on the principles of body mechanics prior to practice of moving, lifting, and transferring. 7.2. Adherence to the principle of Body Mechanics while lifting, moving or positioning is mandatory. 7.3. When handling mannequin, use safe patient handling devices to prevent possible injury. 7.4. Electric beds shall be maintained in the lowest position. 7.5. The wheels of all equipment (wheelchairs, stretchers and beds) are to be locked during practice.	**Faculty/Students/Laboratory Supervisor** **Laboratory Supervisor**
	8. Injury Report	
	8.1. Any incident occurring in the skills labs during college hours must be reported immediately to the lab supervisor. 8.2. An incident report form must be filled out and submitted to QAU.	**Laboratory / Clinical Instructor**
	8.3. A faculty member will assess the student/staff and administer first aid as needed.	**Physician/ Nurse**
	8.4. Hotline number 72222 shall be called and to assist in transporting an injured/ill student to a hospital.	**Safety & Security Unit Manager**

	8.5. Lab supervisor will follow up with the student within 3 working days.	**Laboratory/Clinical Instructor**
	8.6. A copy of the incident report and a written follow up report will be kept in the student's file.	**QAU**
	9. **In the event of a "Contaminated" needle stick**	
	9.1. The site should be immediately washed with soap and water. 9.2. The incident should be reported. 9.3. The exposure should be assessed (type of fluid, type of needle, amount of blood on the needle, etc). 9.4. Contact the DSFH-IC director in DSFH for proper action to be taken. 9.5. Follow up the status of the injured person.	**Laboratory Supervisor/ Clinical Instructor** **QAU**
	10. Latex allergy	
	10.1. Individuals with latex sensitivity are responsible for notifying lab instructors of anticipated risk of latex sensitivity. 10.2. Individuals having a potential acute latex reaction should notify lab instructor and supervisor and incident report form should also be completed.	**Laboratory Supervisors**
	11. Cleaning of laboratory and equipment	
	11.1. The lab supervisor will be responsible for the disinfection and maintenance of equipment, and monitoring of the lab operation.	**Laboratory Supervisors**
	11.2. Students and instructors are responsible for the cleanliness of the lab during and after use.	**Students**
	11.3. Floors, counters and furniture will be cleaned by lab cleaner at the end of each day and more frequently if needed.	**Laboratory Supervisors**

		11.4. Equipment located in the skills lab will be cleaned after each skills lab section and more often as necessary with the appropriate cleaning agent. 11.5. Linen on beds will be changed when soiled or after extensive use. 11.6. Bedspreads may be used more than once during return demonstration of bathing. 11.7. Soiled linen should be kept in the green plastic bag.	
		11.8. Soiled linen will be cleaned in the DSFH laundry and stored in a clean, closed cabinet.	**Housekeeper**